GUY'S
HOSPITAL
GAZETTE

92
1978

WILLS
LIBRARY

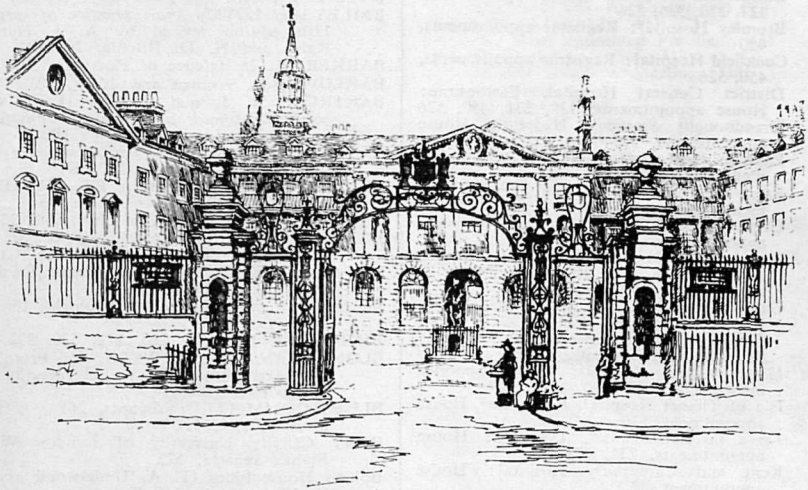
Guy's Hospital Gazette.

Guy's Hospital Gazette.

THE WILLS LIBRARY
10 APR 1981
ROYAL MEDICAL SCHOOL
THE WILLS LIBRARY
GUY'S HOSPITAL
LONDON, S.E.1.

Guy's Hospital Gazette

INDEX TO VOLUME 92



Guy's Hospital, Main Entrance.

1978

INDEX

C—Correspondence P—Passim R—Review

A

Acute confusional states: three cases from general practice (R. M. Turner), 250

ADAMS, G. L., BOIES, L. R. *and* PAPARELLA, M. M. *Fundamentals of otolaryngology*, 429 (R)

ADRIAN STOKES MEMORIAL FELLOWSHIP, 175

AINSWORTH, J. B. L. Homoeopathy—the continuing paradox, 344

ALCOHOL EDUCATION CENTRE: Course, *The representation of alcoholism in cinema and television*, 224

ALFRED RYCROFT SCHOLARSHIP, 376

AMENTA, P. S. *Histology*. 2nd edition, 317 (R)

AMERICAN COLLEGE OF SURGEONS. *Committee on Pre- and Postoperative Care. Manual of surgical intensive care*, 261 (R)

Anatomical education (K. Parsons), 118 (C)

ANGELL, J. C. *The acute abdomen for the man on the spot*, 360 (R)

APPOINTMENTS
- Ashford Hospital, Kent: House appointments, 127, 128, 270, 450, 525, 527
- Beckenham Hospital: House appointments, 127, 270, 525, 526
- Bromley Hospital: Registrar appointments, 450
- Cuckfield Hospital: Registrar appointments, 450, 526
- District General Hospital, Eastbourne: House appointments, 128, 271, 450, 526
- Dreadnought Seamen's Hospital: House appointments, 527
- Edgware General Hospital: House appointments, 128, 271, 450, 527
- Farnborough Hospital: Registrar appointments, 450
- Great Ormond Street Hospital: Registrar appointments, 450
- Greenwich District Hospital: House appointments, 128, 270, 525, 526
  Registrar appointments, 450
- Guy's Hospital: House appointments, 126, 269, 371, 449, 524, 525
  Junior staff appointments, 447
  Registrar appointments, 449
- Hither Green Hospital: House appointments, 127, 128, 270, 525, 527
- Isle of Thanet Hospital, Ramsgate: House appointment, 526
- Joyce Green Hospital, Dartford: House appointments, 271, 526
- Kent and Canterbury Hospital: House appointment, 527
- Lewisham Hospital: House appointments, 127, 128, 270, 525, 527
  Registrar appointments, 450
- New Cross Hospital: House appointments, 127, 270, 449, 525, 526
  Registrar appointments, 450
- Orpington Hospital: House appointments, 127, 128, 270, 525, 527
- Pembury Hospital: House appointments, 127, 128, 271, 525, 527
  Registrar appointment, 450
- St. Helen's Hospital, Hastings: House appointments, 127, 128, 271, 527
- St. Mary's Hospital, Eastbourne: House appointment, 527
- St. Nicholas' Hospital, Plumstead: House appointments, 127, 128, 271
- St. Olave's Hospital: House appointments, 127, 270, 449, 525, 526
  Registrar appointments, 450
- West Kent Hospital: House appointments, 526
- West Suffolk Hospital, Bury St. Edmunds: House appointment, 271, 526

APPOINTMENTS VACANT
- Guy's Hospital Medical School: Department of Medicine: Junior lecturer, 175

ARMSTRONG, D. Unit of Sociology as applied to Medicine [Freshers' edition], 384
- What is wrong with the N.H.S.? 30, 313 (C)

ARTHUR DURHAM TRAVELLING STUDENTSHIP, 175

ASBURY, A. K. *and* JOHNSON, P. C. *Pathology of peripheral nerve*. (Major problems in pathology—9), 424 (R)

ASSOCIATION OF MEDWAY DENTISTS. Opportunities for dental practice in the Netherlands, 245

Asthma: ups and downs (G. M. Cochrane), 328

ATKINS, *Sir* H. Down House, the home of the Darwins, 184

AUDIOVISUAL AIDS: Gordon Museum audio-visual section, 443

AVERY JONES, *Sir* F. *See* JONES, *Sir* F. A.

B

B.M.S. Psychology as applied to Medicine [Freshers' edition] (J. Weinman), 383

BACCHUS, *pseud.* The gods reply, 118 (C)

BAILEY *and* LOVE's *Short practice of surgery*. 17th edition revised by A. J. Harding Rains *and* H. D. Ritchie, 263 (R)

BARKER, A. In defence of Horrobin, 516 (C)

BARLOW, Sue. Women and drugs, 240

BARTRUM, R. J. *and* CROW, H. C. *Grey scale ultrasound; a manual for physicians and technical personnel*, 429 (R)

BATES, J. F. *Removable partial denture construction*. 2nd edition, 512 (R)

BEANEY SCHOLARSHIP IN MATERIA MEDICA, 175

BINNIE, W: Macdonald Cup champion, 223

BIOCHEMISTRY: The preclinical course (W. Scott-Smith), 77 (C), 165 (C), 215 (C)

Biochemistry and Chemistry Department [Freshers' edition] (A. Diplock), 382

Biochemistry and medicine (A. Diplock), 165 (C), 215 (C)

BIRTHS, 84, 128, 176, 220, 272, 320, 372, 528

BLONDSTEIN, I. *and* WEBB, F. From the P[opular] F[ront for the] L[iberation of] A[ardvark], 316 (C)

BLUES COMMITTEE: Awards, 265
- meeting, 48, 134, 378

BOAT CLUB: University of London Winter Eight's regatta, 522

Boland House blues (T. A. Underwood *and* K. O. Underwood), 119 (C)

BONO, E. de. *Lateral thinking:* address to the Quodlibet Society, 230

BONSOR, *Sir* Cosmo *and Lady* Mabel, SCHOLARSHIP, 451, 527

BOOK EXCHANGE: Closure, 50

BOROUGH: Public houses
- Open letter to the gods (P. J. Howatt), 75 (C)
- The gods reply (Bacchus, *pseud.*), 118 (C)

BREWING
- I brew—therefore I fart (K. Gillman), 197

BRIMBLECOMBE, F. *and* BARLTROP, D. *Children in health and disease*, 114 (R)

Britain's armed forces; what are they for? address to the Quodlibet Society (B. Ranft), 502

BRITISH DENTAL ASSOCIATION—DENTSPLY INTERNATIONAL: Annual prize, 376

BRITISH HOMOEOPATHIC ASSOCIATION
- Homoeopathy—the continuing paradox (J. B. L. Ainsworth), 344

BRITISH MEDICAL ASSOCIATION
Central Ethical Committee. Ethics and computers (J. Dawson), 199
Lambeth and Southwark Division
annual dinner 1978, 461
consultants—general practitioners' annual meeting 1978, 461
programme 1979, 461
BROOKS, C. The threat of fascism, 77 (C)
BURFOOT, A. H. 11–19 St. Thomas Street—opposite Conybeare House, 189
BURGEN, A. S. V. *and* MITCHELL, J. F. *Gaddum's Pharmacology,* 214 (R)
"BUTCH", alias of Thomas Guy. Gazette interview, 484
BUTTERFIELD, W. J. H: Created Kt.B, 3

C

CAHILL, W. A. Cricket casualty, 365 (C)
Candidates for medicine? (S. J. Wheeler), 38 (C)
CANN, R. C. Fifty years ago at Guy's, 488
CARMICHAEL, J. A. G: Created C.B, 223
CARTER, C. O. *Human heredity,* 114 (R)
CASH, Joan E. *Neurology for physiotherapists.* 2nd edition, 73 (R)
CASHMORE, W. W: Awarded O.B.E, 3
CASSELL, E. J. *The healer's art: a new approach to the doctor patient relationship,* 316 (R)
CENTRAL EXAMINING BOARD FOR DENTAL HYGIENISTS: Certificate of Proficiency in Dental Hygiene: Pass list, 176
CHALLACOMBE, S. J. H.O.P. [Opening hours of the bar], 117 (C)
Vaccination against dental caries, 58
CHAMBERLAIN'S WHARF: Rejection of plans for private hospital, 177 (P)
On building a private hospital near Guy's (T.L.T. Lewis), 190
CHANGES OF ADDRESS, 44, 84, 128, 176, 220, 272, 320, 372, 451, 528
CHAPEL, 145
Christmas services 1978, 460
CHARLES SYMONDS WARD: Combined stroke rehabilitation unit, 224
CHARTERED SOCIETY OF PHYSIOTHERAPY: Pass lists, 125, 272, 371
Childbirth in a scientific community (N. G. J. Pipe), 232
CHINA: Health care (R. Stott), 62
CHISHOLM, D. M. *et al. Introduction to oral medicine,* 263 (R)
CHRISTMAS, F. [Nicholas]. The case of Regina v. F. Christmas (J. Pini), 473
CIBA FOUNDATION LIBRARY, 224
CLARK, T. Where have all the doctors gone—the Sub-Dean replies, 364 (C)
CLARKE, *Sir* C: Appointed editor, *Journal of Medical Genetics,* 1970, 322
CLIFFORD, Margaret *and* DRUMMOND, Ann. *Radiographic techniques related to pathology.* 2nd edition, 75 (R)
Clinical course, new: a S.M.E.C. survey (P. O'Hare), 254
CLINICAL CURRICULUM, 45 (P), 254
Clinical lecture series: advanced sessions, 47, 86
Closeness to the patient. (Issues in general practice) (S. E. Openshaw), 495
CLUBS' UNION, 52, 260 (C)
annual general meeting, 7
bar, 8, 52, 119 (C), 129 (P), 137, 215 (C), 260 (C)
chairman, 87
constitution, 47, 116 (C), 134, 462
general meetings, 454
membership, 90, 324
N.U.S. Health student policy conference, 8
Physiotherapists and Radiographers rejected, 324
presidential address, 48
student grants, 180
summer festival and sports day, 48, 87, 265
women's common room, 229
COCHRANE, G. M. Ups and downs of asthma, 328
COHEN, S: Awarded C.B.E, 3
Development of a malaria vaccine, 151
Elected F.R.S, 130
COLLING, A. *editor. Coronary care in the community,* 513 (R)
COMPUTERISED TOMOGRAPHY, 274 (P), 362 (C)
Computerised tomography: a brief history, 280
General purpose (whole body) scanning and Guy's Hospital (A. J. S. Saunders), 303
The impact of CT scanning on neurological practice (R. A. C. Hughes), 284
The physical basis of CT scanning (S. J. Wyard), 281
The whole-body scanner in clinical practice (J. de Winter), 289
Computerised tomography: a brief history, 280
Confusional states, acute: three cases from general practice (R. M. Turner), 250
CONN, H. F. *editor. Current therapy 1978,* 428 (R)
CREST, 87
Cricket casualty. [Fixture between Guy's and Cuckfield] (W. A. Cahill), 365 (C)
CRICKET CLUB, 218, 431 (C)
Dr. Scott appointed President, 458
Hospitals' cup, 266, 318
Russell Brock v. Starling, 318
tour, 367
v. Cuckfield, 365
v. Highland Court, 267
v. Middlesex Hospital, 266
v. Nomads, 266
v. Stoics, 266
v. Westminster, 318
v. Woldingham, 266
CROOK, J. C: Promoted to Major-General, 48
CROSS, W. G. *Ruddigore,* 260 (C)
CUST, G. The Health Education Council and its work, 338

D

DANN, E: Gazette interview with Eric Dann, Head Groundsman, Honor Oak Park sports ground, 120
DARKE, C. S. Appointed chief medical officer, Private Patients Plan, Tunbridge Wells, 3
DAVIS, A. *editor. Relationships between doctors and patients,* 162 (R)
DAVIS, H. *and* SILVERMAN, S. R. *Hearing and deafness,* 429 (R)
DAWSON, J. Ethics and computers, 199
DEATHS, 44, 84, 91, 176, 220, 272, 320, 372, 451, 528
DE BONO, E. *See* BONO, E. de
DENNING, D. Cover up? [Constitution of the Clubs' Union] 116 (C)
Surgical firms outside Guy's, 365 (C)
DENNIS, J. What is wrong with the N.H.S? 40 (C)
DENNIS DEUCHAR MEMORIAL PRIZE AWARD, 180
DENTAL CARIES: Vaccination (S. J. Challacombe), 58
DENTAL CLINICAL DAY, 4, 87, 432 (C)
programme, 22, 378
DENTAL HYGIENISTS, Central Examining Board: Certificate of Proficiency in Dental Hygiene: Pass lists, 176.
Dental practice in the Netherlands: Opportunities (Association of Medway Dentists), 245
DENTAL REVUE, 1978, 375

DENTAL REVUE, 1977: The Faulty Tower, 18 (R)
DENTAL SOCIETY. *See* Guy's Hospital Dental Society
Dental surgery: the founding of, at Guy's (F. J. Pearce), 405
DEUCHAR, Dennis, MEMORIAL PRIZE AWARD, 180
DEWHURST, K. *and* REEVES, N. *Friedrich Schiller: medicine, psychology and literature*, 508 (R)
DIETETIC DEPARTMENT: Students, 125
DIPLOCK, A. T. Biochemistry and medicine, 165 (C)
The Department of Biochemistry and Chemistry [Freshers' edition], 382
Gazette interview with Professor A. T. Diplock, 10
DR. JAMES LEIGHTON HOPKINS TRAVELLING SCHOLARSHIP, 175
The domiciliary visit. (Issues in general practice) (R. Goulston), 402
DOUGLAS, Peggy, *jt. author. See* FABRICUS, Julia *and* DOUGLAS, Peggy, 167 (C)
Down House: the home of the Darwins (*Sir* H. Atkins), 184
DOWNIE, Patricia A. *Cancer rehabilitation: an introduction for physiotherapists and the allied professions*, 115 (R)
DRAPER, P. What is wrong with the N.H S? 40 (C)
See also POPAY, Jennie *and* DRAPER, P. 153
DRY FLY FISHING CLUB, 367, 433 (C)
DURHAM, Arthur, TRAVELLING STUDENTSHIP, 175

E

E.M.I. scanner, 274 (P), 280, 362 (C), 432 (C)
Early days. (An excerpt from Professor Simpson's autobiography "40 years of murder") (K. Simpson), 394
Edmonton 1978: psychology and the superior sportsman (M. Yaffé), 348
ELIZABETH GARRETT ANDERSON HOSPITAL: Threatened closure, 221 (P), 312 (C)
ELLIS, F. Surgery—too little, science—too much, 476
ELLIS, H. Royal operations: address to the Pupils' Physical Society, 417
EMSLIE, R. D. Annual Dental Clinical Day, 432 (C)
From the Dean of Dental Studies [Freshers' edition], 380
ENDEAN, F. C: Obituary, 327
ENGAGEMENTS, 128, 220, 372, 451, 528
ESCOUROLLE, R. *and* POIRIER, J. *Manual of basic neuropathology*, 317 (R)
Ethics and computers (J. Dawson), 199
EVELINA CHILDREN'S DEPARTMENT: Analysis of 100 consecutive, acute admissions (Camilla H. Haw), 205
EVELYN SPRAWSON PRIZE, 460
EVERTON, S. J. Opera at the Grenwood, 117 (C)
EXAMINATION PASS RATES: M.B, B.S, 273 (P), 363 (C), 433 (C)
EXAMINING BOARD IN ENGLAND: Pass lists: M.R.C.S, L.R.C.P, 83, 527

F

FABRICUS, Julia *and* DOUGLAS, Peggy. Sisters on beds, 167 (C)
FARMER, Jean. The questions you ask us [Freshers' edition], 386
FASCHINGBAUER, T. S. *and* NEWMARK, C. S. *Review of short forms of the M.M.P.I*, 426 (R)
FASCISM, 1 (P), 77 (C)
FELLOWSHIPS
Adrian Stokes memorial fellowship, 175
Hilda and Ronald Poulton fellowship, 175
Sir Alfred Fripp memorial fellowship, 175
Fifty years ago at Guy's (R. C. Cann), 488
FILM REVIEWS, 28 (R), 68 (R), 111 (R), 210 (R), 252 (R), 354 (R), 419 (R)
FILM SOCIETY: Programme, 50
FILMS AND THEATRE, 210 (R), 419 (R)
The firm dinner (C.M.H.), 256
FITZGERALD, M. J. T. *Human embryology*, 430 (R)
FORREST, W. I. N. St. Guy of Regent's Park, 517 (C)
FORSYTHE, M: Appointed regional medical officer, South-east Thames R.H.A, 3
40 years of murder (K. Simpson), 394, 464, 508 (R)
FOX, H. *The pathology of the placenta*, 359 (R)
FRANCIS, G. H.O.P. bar, 76 (C)
FRANCIS LETT SCHOLARSHIP, 175
FRASER ROBERTS, J. A. *See* ROBERTS, J. A. Fraser *and* PEMBREY, M. E. 510 (R)
FREEZER, C. R. E: New pathology department building, East Glamorgan General Hospital, named the Charles Freezer Laboratory, 3
French spas, in praise of (Camilla M. Haw), 415
FRESHERS, 380
freshers' fair, 322
Gazette edition, 322
Welcome to Guy's, 380
FRIENDS OF GUY'S HOSPITAL: Christmas stall, 7
Scottish evening, 7, 117 (C)
FRIPP, *Sir* Alfred, MEMORIAL FELLOWSHIP, 175
FUERST, R. *Microbiology in health and disease*. 14th edition, 359 (R)

G

GARDNER, M. L. G. *Medical acid-base balance: the basic principles*, 424 (R)
GARDNER, W. D. *and* OSBURN, W. A. *Anatomy of the human body*. 3rd edition, 426 (R)
GAUVAIN, Suzette Occupational medicine: Gazette interview, 192
GELBIER, S. *and* COPLEY, Margaret A. H. *Handbook for dental surgery assistants and other ancillary workers*. 2nd edition, 36 (R)
GENERAL PRACTICE: *Issues in general practice series*
Closeness to the patient (S. E. Openshaw), 495
The domiciliary visit (R. Goulston), 402
GENERAL PRACTICE, students in: the third of four papers presented to the 4th annual meeting of G.P.s and Hospital Consultants of the Guy's Health District (P. M. Higgins), 108
GENERAL PRACTITIONER MEETINGS, 4, 108, 131
GILBERT AND SULLIVAN SOCIETY, 167 (C)
Ruddigore, 49, 95 (R), 165 (C), 167 (C), 260 (C)
Salad Days, 375, 388
GILLMAN, K. I brew—therefore I fart, 197
GITTINGS, R. Address on Keats to the Quodlibet Society, 56
GOLF CLUB, 439
consultants' match, 368
Macdonald cup winner, 223
Past v. Present, 269
President's match, 268
GOODENOUGH, Ursula. *Genetics*. 2nd edition, 425 (R)

GORDON MUSEUM: Audiovisual section, 443
Dunhill Dermatology section, 446
hours of opening, 322, 355
GOULSTON, R. The domiciliary visit. (Issues in general practice), 402
GRAHAME, R. Rheumatology in the community: the second of four papers presented to the 4th annual meeting of G.P.s and hospital consultants of the Guy's Health District, 66
GRANT, E. Mary. Thirty years on, 166 (C)
Where lies the blame [for nursing staff shortages], 312 (C)
GREENWOOD THEATRE: Opera at the Greenwood (S. J. Everton), 117 (C)
[GUY, the gorilla] St. Guy of Regent's Park (W. I. N. Forrest), 517 (C)
GUY, Thomas, *alias* "Butch". Gazette interview with Thomas GUY, 484
GUY'S ARTHRITIS RESEARCH UNIT: Nordic Symposium in Rheumatology, 2nd, 50
GUY'S HOSPITAL
beds, 167 (C)
combined stroke rehabilitation unit, 224
Fifty years ago at Guy's (R. C. Cann) 488
fire in Works Department, 374
patient care, 431 (C), 515 (C)
rearrangement of surgical firms, 323
shutdown of heating system, 50
ward closures, 179
GUY'S HOSPITAL BIENNIAL DINNER, 134, 279
GUY'S HOSPITAL DENTAL SCHOOL
Alfred Rycroft scholarship, 376
annual clinical day, 4, 22, 87, 378
dental diary, 5, 51, 88, 132, 178, 226, 276, 324, 432 (C)
dental revue, 18 (R), 375
dental travelling scholarship, 44
Evelyn Sprawson prize, 460
foundation, 411
Newland-Pendley travelling scholarship, 44
GUY'S HOSPITAL DENTAL SOCIETY
annual dinner and ball, 24, 78 (C)
programme, 379
relationship with Clubs' Union, 55
A wondering dentist: presidential address (M. L. Maberley), 404
GUY'S HOSPITAL GAZETTE
appointment of Patricia Poulter as manager, 458
appreciation of Richard Henderson, 145
appreciation of Stephanie Amiel, 144
cover, 5
editorial appointments, 134, 374
financial difficulties, 322
interview with Eric Dann, Head Groundsman, Honor Oak Park sports ground, 120
interview with Professor A. T. Diplock, 10
interview with Thomas Guy, *alias* "Butch", 484
Occupational medicine: interview with Dr. Suzette Gauvain, 192
subscription increases, 240
GUY'S HOSPITAL MEDICAL SCHOOL
clinical curriculum, 45 (P), 254
clinical students work as nurses, 458
M.B., B.S., examination pass rates, 273 (P), 363 (C)
medical diary, 4, 51, 88, 132, 178, 226, 275, 324, 378
Postgraduate Studies department: diary, 178
student selection, 38 (C)
GUY'S HOSPITAL MUSIC CLUB
Christmas concert, 27 (R)
Easter concert, 49
Handel's *Messiah,* 322, 376, 458
GUY'S HOSPITAL PUPILS' PHYSICAL SOCIETY. *See* Pupils' Physical Society
GUY'S HOSPITAL SCHOOL, 146
GUY'S HOSPITAL SOCIETY
The 1928 dining club (Elizabeth R. Scott), 515 (C)
South Wales and Monmouthshire, 5, 142
GUY'S TOWER: Collapse of chimneys, 222 (P), 228, 376

H

H, C.M. The firm dinner, 256
HALL, T. J. C: Awarded O.B.E, 223
HANSHAW, J. B. *and* DUDGEON, J. A. *Viral diseases of the fetus and newborn,* 262 (R)
HARDY, R. H. *Accidents and emergencies: a practical handbook for personal use.* 2nd edition, 164 (R)
HARE AND HOUNDS CLUB, 39 (C)
HASLEWOOD, G. A. D. [Patient care in Guy's Hospital], 431 (C)
HAW, Camilla H. An analysis of 100 consecutive, acute admissions to the Evelina Children's Department, 205
In praise of French spas, 415
Health care in China (R. Stott), 62
The Health Education Council and its work (G. Cust), 338
HEARD, R. *jt. author. See* NEWTON, Rosalind, HEARD, R, LIND, M. *and* SNAPE, A, 186
HEATNG SYSTEM: Shutdown, 50
HELLIWELL, P. J. Miss Rene Knight, 517 (C)
HENDERSON, R. A Punjabi elective, 99
HETT, D. A. The Hockey Club, 216 (C)
HIGGINS, P. M. Students in general practice: the third of four papers presented to the 4th annual meeting of G.P.s and Hospital Consultants of the Guy's Health District, 108
HILDA AND RONALD POULTON FELLOWSHIP, 175
HILLMAN, Leslie, PRIZE IN HAEMATOLOGY, 528
HOARE, R. D. Computerised tomography, 362 (C)
HOCKEY CLUB, 216 (C), 438
Past v. Present, 4
Spirochaetes v. Chancres, 520
United Hospitals' cup, 79
v. Deal, 520
v. Edenbridge, 520
v. London Hospital, 520
v. Medway, 520
v. St. Mary's Hospital, 79
Homoeopathy—the continuing paradox (J. B. L. Ainsworth), 344
HONOR OAK PARK: Bar opening hours, 38 (C), 76 (C), 117(C)
Gazette interview with Eric Dann, Head Groundsman, 120
HOPKINS, Dr. James Leighton, TRAVELLING SCHOLARSHIP, 175
HORROBIN, D. F. *Medical Hubris: a reply to Ivan Illich,* 361 (R), 516 (C)
HOSPITAL INFORMATION, 44, 83, 125, 174, 219, 269, 319, 369, 446, 524
HOSPITALS' CHRISTMAS CAROL CONCERT, 26 (R)
HOULDING, T. [Students' bar], 215 (C), 260 (C)
HOUSTON, J. C. Message from the Dean [Freshers' edition], 380
HOUSTON, W. J. B. *and* ISAACSON, K. G. *Orthodontic treatment with removable appliances,* 37 (R)
HOWATT, P. J. Open letter to the gods [public houses in the Borough], 75 (C)
HUGHES, R. A. C. The impact of CT scanning on neurological practice, 284
HUNT'S HOUSE: Ward closures, 179
HUTTON, Enid M. Scottish evening—Friends of Guy's, 117 (C)

I

INFLUENZA VACCINES: " Red flu" jabs, 47
INGRAM, F. L: Appreciation, 278
ISSUES IN HEALTH GROUP, 97
address by Dr. John Yudkin, *The drug companies and health*, 98
meetings programme, 49, 178

J

JACKSON, W: Appointed medical editorial director, *Medicine*, 175
JACOB, S. W., FRANCOMBE, C. A. *and* LOSSOW, W. J. *Structure and function in man*. 4th edition, 426 (R)
JONES, *Sir* F. A. What went wrong with the N.H.S? [Address to the London Medical Group], 103
JOSPE, M. *The placebo effect in healing*, 424 (R)

K

KAPLAN, Helen S. *The new sex therapy: active treatment of sexual dysfunctions*, 162 (R)
KEATS-SHELLEY MEMORIAL APPEAL FUND: Donation from the Council of Governors, 7
KILBY, J. V. Private hospitals and medical care, 259 (C)
KNIGHT, Rene: Retirement, 517 (C)
KRAUS, R. *editor. Therapeutic recreation service: principles and practices*. 2nd edition, 427 (R)
KRUGMAN, S. *and* GOCKE, D. *Viral hepatitis*, 425 (R)

L

L, D.J. [Female member of the Hare and Hounds Club team], 39 (C)
LAING, R. D. Address to the Quodlibet Society, 504
LAMBETH, LEWISHAM AND SOUTHWARK A.H.A: Proposed spending cuts, 131
LANGLAIS, R. P. *and* KASLE, M. J. *Intraoral radiographic interpretation*, 513 (R)
LANGLEY, L. S: From Lane to the milk churn (K. M. Pagliero), 313 (C)
Lateral thinking: address to the Quodlibet Society (E. de Bono), 230
LAWRIE, Jean. From the Action Committee, E.G.A, 312 (C)
LESLIE HILLMAN PRIZE IN HAEMATOLOGY, 528
LESSOF, M. H. What is wrong with the N.H.S? 39 (C)
LETT, Francis, SCHOLARSHIP, 175
LEWIS, T. L. T: Elected chairman, Clubs' Union, 87
A history of Guy's Hospital Rugby Football Club, 390, 497
On building a private hospital near Guy's, 190, 458
LIDDELOW, K. P: Awarded C.B.E, 3
LIND, M, *jt. author. See* NEWTON, Rosalind, HEARD, R, LIND, M. *and* SNAPE, A, 186
LLEWELLYN-JONES, D. *Everywoman—a gynaecological guide for life*. 2nd edition, 163 (R)
LOMAN, S. Third World comment [on hospital expenditure in the western world], 432 (C)
LONDON: University
M.B., B.S. examination pass rates, 273 (P), 363 (C)
Pass lists: B.D.S. 83, 370
M.B. 320, 369, 527
M.Sc. 272, 527
Ph.D. 83, 219, 272, 320, 369
Preliminary examination for Studies in Medical Subjects, 369, 527
Second examination in Dental Surgery, 83
special lecture, 323
U.L.U. *H.M.S. Pinafore*, 28 (R)
U.L.U. *The Sorcerer*, 139 (R)
LONDON BRIDGE STATION: Reconstruction, 16
LONDON MEDICAL GROUP: Address by Sir Francis Avery Jones, *What went wrong with the N.H.S?* 103
lectures, 379
LYON, D. Guy's sport, 515 (C)

M

M.B., B.S. EXAMINATION PASS RATES, 273 (P), 363 (C)
MABERLEY, M. L. A wondering dentist: presidential address to the Guy's Hospital Dental Society, 404
McCANCE, D. Salmonellosis, 158
MACDONALD, I. The Physiology Department [Freshers' edition], 382
MacFARLANE, D. A. *and* THOMAS, L. P, *eds. Textbook of surgery*. 4th edition, 115 (R)
MACKENZIE, I: Appreciation, 326
MacLEAN, J: Awarded O.B.E, 48
MACLEOD, J. *editor. Davidson's Principles and practice of medicine*. 12th edition, 261 (R)
MacMANUS, Emily E: obituary, 92
thanksgiving service, 134, 180
Malaria vaccine: Development (S. Cohen), 151
MARRIAGES, 128, 320, 372, 528
MARTIN, E. A. *and* COOLIDGE, A. A. *Nutrition in action*, 424 (R)
MASON, Rita A. *A guide to dental radiography*, 74 (R)
MATHEWSON, J. G: Obituary, 328
MATTHEWS, N. [Students' bar] "The Bar Secretary replies", 215 (C)
MAX: Death, 179
MAXWELL, G. I. Guy's [I.L.E.A.] Hospital school, 146
MAYSON, N. Guy's Hospital Dental Society dinner, 78 (C)
MEDICAL SOCIETY OF LONDON: Presidential address by F. Ellis, *Surgery—too little, science—too much*, 476
MESCHAN, I. *Synopsis of radiologic anatomy with C.T*, 359 (R)
MILLER, B. F. *and* KEANE, Claire B. *Encyclopedia and dictionary of medicine*, 427 (R)
MODEL RAILWAYS: Playing trains or modelling railways? (T. Watson), 17
MOORE, M. L. *Realities in childbearing*, 509 (R)
MORAGAS, A, BALLABRIGA, A. *and* VIDAL, M. T. *Atlas of neonatal histopathology*. 427 (R)
MORGAN, A. T. Love on all courts, 260 (C)
MOUNTAINEERING CLUB, 318, 441
annual dinner meet, 82
expedition to Kjölur, 439
MOWSCHENSON, P. M. *Aids to undergraduate surgery*, 514 (R)
MURPHY, T. R. *Regional anatomy: multiple choice questions*, 511 (R)
MUSIC CLUB. *See* Guy's Hospital Music Club

N

NATIONAL HEALTH SERVICE, 431 (C)
Thirty years on (E. Mary Grant), 166 (C)
What is wrong with the N.H.S.? 30, 39 (C), 76 (C), 258 (C), 313 (C)
What went wrong with the N.H.S.? [address to the London Medical Group] (*Sir* F. A. Jones), 103
NATIONAL UNION OF STUDENTS: Health student policy conference, 8
NAYLOR, M. N. Delivers medal lecture of the Society of Cosmetic Chemists of G.B, *Dental health—a community responsibility*, 130
NETHERLANDS: Opportunities for dental practice (Association of Medway Dentists), 245
NEWLAND - PEDLEY TRAVELLING SCHOLARSHIP, 44
NEWTON, Rosalind, HEARD, R, LIND, M. *and* SNAPE, A. A week in the pharmaceutical industry, 186
NICHOLLS, E. *Endodontics*. 2nd edition, 73 (R)
The 1928 dining club (Elizabeth R. Scott), 515 (C)
NURSES AND NURSING
administrators, 310
attention to detail, 421
doctors' views, 357
integrity, 506
morale in the N.H.S, 160
negotiations, 33
The nursing process, 256
pass lists, 371
patient care, 112
pay forms, 422
political involvement, 71
staff shortages, 312 (C)
work routines, 212

O

OBITUARIES
F. C. Endean, 327
I. Mackenzie, 326
Emily E. P. MacManus, 92
J. G. Mathewson, 328
A. R. Phillips, 327
T. G. Pritchard, 9
A. T. Rivers, 9
Marv D. Sheridan, 93
R. Tilley, 229
Occupational medicine: Gazette interview (Suzette Gauvain), 192, 312 (C)
O'HARE, P. The new clinical course: a S.M.E.C. survey, 254
OLD GUY'S HOUSE: Colour prints of Piper's painting (A. Williams), 365 (C)
OLYMPIC GAMES: Edmonton 1978: psychology and the superior sportsman (M. Yaffé), 348
OPENSHAW, Susan E. Closeness to the patient. (Issues in general practice), 495
ORAL HYGIENE CENTRE, 202
ORCHARD LISLE SWIMMING POOL: Hours of opening, 228, 377
OSBORN, J. W: Appreciation, 143
A national health service? 39 (C)

P

PAGLIERO, K. M. From Lane to the milk churn [Mr Lionel Scott Langley], 313 (C)
PAPERS BY GUY'S MEN, 44, 125, 174, 219, 271, 319, 369, 446, 524
PAPPWORTH, M. H. *A primer of medicine*. 4th edition, 428 (R)
PARKS, A: Created Kt, 48
PARSONS, K. Anatomical education, 118 (C)
PASS LISTS
Central Examining Board for Dental Hygienists: Certificate of Proficiency in Dental Hygiene, 176
Chartered Society of Physiotherapy, 125, 272, 371
Examining Board in England: M.R.C.S, L.R.C.P, 83, 527
Royal College of Pathologists, 83
Royal College of Surgeons of England:
Diploma in Dental Public Health, 527
F.D.S, 219, 369, 527
F.R.C.S, 83, 369
L.D.S, 125, 527
Royal Colleges of Physicians of the U.K, 83
Thomas Guy School of Nursing, 371
University of London:
B.D.S, 83, 369
M.B, 320, 369, 527
M.Sc, 272, 527
Ph.D, 83, 219, 272, 320, 369
Preliminary examination for studies in Medical Subjects, 369, 527
Second examination in Dental Surgery, 83
PASSIM, 1, 45, 85, 129, 177, 221, 273, 321, 373, 454
Pathology Department [Freshers' edition] (D. R. Turner), 385
PEARCE, F. J. The founding of dental surgery at Guy's, 405
PELMEAR, P: Appointed editor, *Journal of the Society of Occupational Medicine*, 1976, 322
PENNEY, A: Expedition to commemorate Drake's circumnavigation of the world, 375
PERSONAL, 44, 84, 176, 220, 272, 372, 451, 528
PHARMACEUTICAL INDUSTRY: A week in the pharmaceutical industry (Rosalind Newton, R. Heard, M. Lind *and* A. Snape), 186
Pharmacology Department [Freshers' edition] (R. Spector), 385
PHILLIPS, A. R: Obituary, 327
PHILLIPS, Tania. The working mother, 233
PHYSICAL SOCIETY. *See* Pupils' Physical Society
The Physiology Department [Freshers' edition] (I. Macdonald), 382
PHYSIOTHERAPISTS AND PHYSIOTHERAPY
annual charity ball, 86
annual meeting, 130
community role, 311
degree courses, 34
deployment of staff, 213
graduate course, 507
joint remedial professions course, 423
professional hierarchy, 356
research, 113, 257
sports injuries, 257
staff establishment, 70
student selection, 161
PINI, J. The case of Regina v. F. Christmas, 473
PIPE, N. G. J. Childbirth in a scientific community, 232
Pleasure and prevention: effective prevention without being a kill-joy (Jennie Popay *and* P. Draper), 153
POLITICAL PARTIES, 321 (P)
POPAY, Jennie *and* Draper, P. Pleasure and prevention: effective prevention without being a kill-joy, 153
PORTNEY, W. M. *Emergency medical care*, 360 (R)
POULTER, Patricia: Appointed manager, Guy's Hospital Gazette, 458
POULTON, Hilda *and* Ronald, FELLOWSHIP, 175
The preclinical biochemistry course (W. Scott-Smith), 77 (C), 165 (C), 215 (C)
PRITCHARD, T. G: Obituary, 9

PRIVATE PRACTICE, 177 (P), 259 (C)
On building a private hospital near Guy's (*T. L. T. Lewis*), *190*, 458
PRIZES AND AWARDS, 49, 132, 179, 276
Dennis Deuchar memorial prize award, 180
Evelyn Sprawson prize, 460
Leslie Hillman prize in Haematology, 528
PRYN, W. J: Appointed Command consultant surgeon, British Army of the Rhine, 3
Psychology as applied to Medicine: B.M.S. course [Freshers' edition] (J. Weinman), 383
PUBLIC HOUSES, Borough: Open letter to the gods (P. J. Howatt), 75 (C)
The gods reply (Bacchus, *pseud.*), 118 (C)
PUGH, Doris E. *and* WESTBROOK, Ethel M: Acknowledgement, 39 (C)
PULLEN-WARNER, E. *and* L'ESTRANGE, P. R. *Sectional dentures*, 512 (R)
A Punjabi elective (R. Henderson), 99
PUPILS' PHYSICAL SOCIETY, 2 (P), 48, 248, 458
inaugural meeting, 61, 87
Professor Harold Ellis on *Royal operations*, 417

Q

QUODLIBET SOCIETY, 140, 184, 351
address by R. D. Laing, 504
Any Questions? 25
Arthur Scargill on "*The current situation*", 183
Edward de Bono on *Lateral thinking*, 230
Peter Webb on *Art and pornography*, 140
Professor Bryan Ranft on *Britain's armed forces; what are they for*? 502
Race and the law, 57
Robert Gittings on *Keats*, 56

R

RACHMAN, S. J. *and* PHILLIPS, C. *Psychology and medicine*, 358 (R)
RADIOGRAPHERS AND RADIOGRAPHY
Radiography in crime (K. Simpson), 335
technique assessment, 35
white coats, 72
RAINS, A. J. Harding. *1,001 multiple choice questions and answers in surgery*, 360 (R)
RANFT, B. *Britain's armed forces; what are they for*? address to the Quodlibet Society, 502
RAY, G. E. *Precision attachments*. (Dental practitioner handbook no. 7), 2nd edition, 317 (R)
READING, R. F. ("Dirty" Dick Reading). [Dry Fly Fishing Club's outing], 433 (C)
REEKIE, I. Guy's sport, 431 (C)
REID, Cynthia. *A primer of human neuroanatomy*, 36 (R)
RESIDENTS' PLAY, 456
REUTER, S. R. *and* Redman, H. C. *Gastrointestinal angiography*, 164 (R)
REVIEWS
G. L. Adams, L. R. Boies *and* M. M. Paparella. *Fundamentals of otolaryngology*, 429 (R)
P. S. Amenta. *Histology*. 2nd edition, 317 (R)
American College of Surgeons. *Committee on Pre- and Postoperative Care. Manual of surgical intensive care*, 261 (R)
J. C. Angell. *The acute abdomen for the man on the spot*, 360 (R)
A. K. Asbury *and* P. C. Johnson. *Pathology of peripheral nerve*. (Major problems in pathology—9), 424 (R)
Bailey *and* Love's *Short practice of surgery*. 17th edition, revised by A. J. Harding Rains *and* H. D. Ritchie, 263 (R)
R. J. Bartrum *and* H. C. Crow. *Grey scale ultrasound: a manual for physicians and technical personnel*, 429 (R)
J. F. Bates. *Removable partial denture construction*. 2nd edition, 512 (R)
F. Brimblecombe *and* D. Barltrop. *Children in health and disease*, 114 (R)
A. S. V. Burgen *and* J. F. Mitchell. *Gaddum's Pharmacology*, 214 (R)
C. O. Carter. *Human heredity*, 114 (R)
Joan E. Cash. *Neurology for physiotherapists*. 2nd edition, 73 (R)
E. J. Cassell. *The healer's art: a new approach to the doctor patient relationship*, 316 (R)
D. M. Chisholm *et al. Introduction to oral medicine*, 263 (R)
Margaret Clifford *and* Ann Drummond. *Radiographic techniques related to pathology*. 2nd edition, 75 (R)
A. Colling, *editor. Coronary care in the community*, 513 (R)
H. F. Conn, *editor. Current therapy 1978*, 428 (R)
A. Davis, *editor. Relationships between doctors and patients*, 162 (R)
H. Davis *and* S. R. Silverman. *Hearing and deafness*, 429 (R)
K. Dewhurst *and* N. Reeves. *Friedrich Schiller; medicine, psychology and literature*, 508 (R)
Patricia A. Downie. *Cancer rehabilitation: an introduction for physiotherapists and the allied professions*, 115 (R)
R. Escourolle *and* J. Poirier. *Manual of basic neuropathology*, 317 (R)
T. S. Faschingbauer *and* C. S. Newmark. *Review of short forms of the M.M.P.I*, 426 (R)
M. J. T. Fitzgerald. *Human embryology*, 430 (R)
H. Fox. *The pathology of the placenta*, 359 (R)
R. Fuerst. *Microbiology in health and disease*. 14th edition, 359 (R)
M. L. G. Gardner. *Medical acid-base balance: the basic principles*, 424 (R)
W. D. Gardner *and* W. A. Osburn. *Anatomy of the human body*. 3rd edition, 426 (R)
S. Gelbier *and* Margaret A. H. Copley. *Handbook for dental surgery assistants and other ancillary workers*. 2nd edition, 36 (R)
Ursula Goodenough. *Genetics*. 2nd edition, 425 (R)
J. B. Hanshaw *and* J. A. Dudgeon. *Viral diseases of the fetus and newborn*, 262 (R)
R. H. Hardy. *Accidents and emergencies: a practical handbook for personal use*. 2nd edition, 164 (R)
D. F. Horrobin. *Medical Hubris: a reply to Ivan Illich*, 361 (R), 516 (C)
W. J. B. Houston *and* K. G. Isaacson. *Orthodontic treatment with removable appliances*, 37 (R)
S. W. Jacob, C. A. Francome *and* W. J. Lossow. *Structure and function in man*. 4th edition, 426 (R)
M. Jospe. *The placebo effect in healing*, 424 (R)
Helen S. Kaplan. *The new sex therapy: active treatment of sexual dysfunctions*, 162 (R)
R. Kraus, *editor. Therapeutic recreation service: principles and practices*. 2nd edition, 427 (R)
S. Krugman *and* D. Gocke. *Viral hepatitis*, 425 (R)
R. P. Langlais *and* M. J. Kasle. *Intra-oral radiographic interpretation*, 513 (R)

D. Llewellyn-Jones. *Everywoman—a gynaecological guide for life*. 2nd edition, 163 (R)
D. A. MacFarlane *and* L. P. Thomas, *eds. Textbook of surgery*. 4th edition, 115 (R)
J. Macleod, *editor. Davidson's Principles and practice of medicine*. 12th edition, 261 (R)
E. A. Martin *and* A. A. Coolidge. *Nutrition in action*, 424 (R)
Rita A. Mason. *A guide to dental radiography*, 74 (R)
I. Meschan. *Synopsis of radiologic anatomy with C.T*, 359 (R)
B. F. Miller *and* Claire B. Keane. *Encyclopedia and dictionary of medicine*. 427 (R)
M. L. Moore. *Realities in childbearing*, 509 (R)
A. Moragas, A. Ballabriga *and* M. T. Vidal. *Atlas of neonatal histopathology*, 427 (R)
P. M. Mowschenson. *Aids to undergraduate surgery*, 514 (R)
T. R. Murphy. *Regional anatomy: multiple choice questions*, 511 (R)
E. Nicholls. *Endodontics*. 2nd edition, 73 (R)
M. H. Pappworth. *A primer of medicine*. 4th edition, 428 (R)
W. M. Portney. *Emergency medical care*, 360 (R)
E. Pullen-warner *and* P. R. L'Estrange. *Sectional dentures*, 512 (R)
S. J. Rachman *and* C. Phillips. *Psychology and medicine*, 358 (R)
A. J. Harding Rains. *1,001 multiple choice questions and answers in surgery*, 360 (R)
G. E. Ray. *Precision attachments*. (Dental practitioner handbook no. 7). 2nd edition, 317 (R)
Cynthia Reid. *A primer of human neuroanatomy*, 36 (R)
S. R. Reuter *and* H. C. Redman. *Gastrointestinal angiography*, 164 (R)
Cecilia M. Roberts. *Doctor and patient in the teaching hospital*, 162 (R), 516 (C)
J. A. Fraser Roberts *and* M. E. Pembrey *An introduction to medical genetics*. 7th edition, 510 (R)
R. B. Rutherford *et al. Vascular surgery*, 361 (R)
D. C. Sabiston. *Textbook of surgery: the biological basis of modern surgical practice*. 11th edition, 358 (R)
E. E. Salcedo. *Atlas of echocardiography*, 430 (R)
K. Simpson. *Forty years of murder*, 508 (R)
G. D. L. Smyth. *Diagnostic E.N.T*, 429 (R)
L. H. Sobin. *A pathology primer—in verse*, 508 (R)
M. Spira. *How to lose weight without really dieting*, 511 (R)
D. Stafford-Clark *and* A. C. Smith. *Psychiatry for students*, 214 (R)
E. B. Steen. *Abbreviations in medicine*. 4th edition, 514 (R)
G. E. Striker *et al. Use and interpretation of renal biopsy*, 263 (R)
R. W. Taylor *and* M. G. Brush. *Obstetrics and gynaecology*, 509 (R)
Theatre, films and television, 28 (R), 68 (R), 111 (R), 210 (R), 252 (R), 307 (R), 352 (R), 419 (R)
M. C. Timbury. *Notes on medical virology*. 6th edition, 115 (R)
G. E. Trease *and* W. C. Evans. *Pharmacognosy*. 11th edition, 164 (R)
D. C. Turk *and* I. A. Porter. *A short textbook of medical microbiology*. 4th edition, 425 (R)
P. Turner *and* G. Volans. *The drugs handbook*, 214 (R)
D. M. Weir. *Immunology: an outline for students of medicine and biology*. 8th edition, 75 (R)
J. Weir *and* P. Abrahams. *An atlas of radiological anatomy*, 426 (R)
L. A. Weisberg, C. Nice *and* M. Katz. *A text-atlas of cerebral computed tomography*, 362 (R)
Rheumatology in the community: the second of four papers presented to the 4th annual meeting of G.P.s and hospital consultants of the Guy's Health District (R. Grahame), 66
RIVERS, A. T: Obituary, 9
ROBERTS, Cecilia M. *Doctor and patient in the teaching hospital*, 162 (R), 516 (C)
ROBERTS, J. A. Fraser *and* PEMBREY, M. E. *An introduction to medical genetics*. 7th edition, 510 (R)
ROBINSON, R. J. Opening times at H.O.P, 38 (C)
ROSEN, B. Treatment contracts at the York Clinic, 157
ROWING CLUB. *See* Boat Club
ROYAL COLLEGE OF PATHOLOGISTS: Pass lists, 83
ROYAL COLLEGE OF SURGEONS OF ENGLAND: Pass lists: Diploma in Dental Public Health, 527
F.D.S, 219, 369, 527
F.R.C.S, 83, 369
L.D.S, 125, 527
ROYAL COLLEGES OF PHYSICIANS OF THE U.K: Pass lists, 83
Royal operations: address to the Pupils' Physical Society (H. Ellis), 417
RUGBY CLUB, 389
Angels v. Edenbridge 1st, 80
1st XV fixtures, 452
history, 390, 497
Present v. Past, 80
reunion weekend, 6
United Hospitals' cup, 79
v. Blackheath, 434
v. Charing Cross Hospital, 79
v. Cheltenham, 434
v. Coventry, 122
v. Havant, 42
v. The London Hospital, 80
v. London Irish, 122
v. Mountain Ash, 518
v. Old Merchant Taylors, 518
v. Old Millhillians, 79
v. Osterley, 518
v. Sutton and Epsom, 43
Vipers tour, 168
RUTHERFORD, R. B. *et al. Vascular surgery*, 361 (R)
RYCROFT, Alfred, SCHOLARSHIP, 376

S

SABISTON, D. C. *Textbook of surgery; the biological basis of modern surgical practice*. 11th edition, 358 (R)
St. Thomas Street, 11-19—opposite Conybeare House (A. H. Burfoot), 189
SALCEDO, E. E. *Atlas of echocardiography*, 430 (R)
Salmonellosis (D. McCance), 158
SAUNDERS, A. J. S. General purpose (whole body) scanning and Guy's Hospital, 303
SCARGILL, A. *The current situation*: address to the Quodlibet Society, 183
SCHOLARSHIPS AND STUDENTSHIPS
Adrian Stokes memorial fellowship, 175
Arthur Durham travelling studentship, 175
Alfred Rycroft scholarship, 376
Beaney scholarship in Materia Medica, 175
dental travelling scholarship, 44
Dr. James Leighton Hopkins travelling scholarship, 175

Francis Lett scholarship, 175
Hilda and Ronald Poulton fellowship, 175
Newland-Pedley travelling scholarship, 44
Sir Alfred Fripp memorial fellowship, 175
Sir Cosmo and Lady Mabel Bonsor scholarship, 451, 527
SCHOOL OF NURSING. *See* Thomas Guy School of Nursing
SCIENCE MUSEUM: Exhibitions, 278
SCOTT, Elizabeth R. The 1928 dining club, 515 (C)
SCOTT-SMITH, W. The preclinical biochemistry course, 77 (C), 215 (C)
Where have all the doctors gone—a student replies, 363 (C), 433 (C)
SHERIDAN, Mary D: Obituary, 93
SIEVERS, P. Guy's sport—the remedy, 515 (C)
SIMPSON, K. *Forty years of murder*, 394, 464, 508 (R)
SIR ALFRED FRIPP MEMORIAL FELLOWSHIP, 175
SIR COSMO AND LADY MABEL BONSOR SCHOLARSHIP, 451, 527
SKINNER, A. P.J.R. is innocent, OK [Review of *Ruddigore*], 165 (C)
SLICKER, *pseud*, 316 (C)
Killing yourself by degrees, 118 (C)
[Shortest books in the world], 167 (C)
SMITH, D. M. What is wrong with the N.H.S. —a reply from across the "Pond", 258 (C)
SMITH, W. Scott- *See* SCOTT-SMITH, W.
SMYTH, G. D. L. *Diagnostic E.N.T*, 429 (R)
SNAPE, A. *jt. author. See* NEWTON, Rosalind, HEARD, R., LIND, M. *and* SNAPE, A.
186
SOBIN, L. H. *A pathology primer—in verse*, 508 (R)
SOCCER CLUB, 217, 436
Cambridge Soccer Club tour, 81
1st XI, 171, 518
referees, 323
2nd XI, 519
3rd XI, 267, 437
United Hospitals' cup, 81, 123
v. Bart's, 436
v. Charing Cross, 123
v. Chelsea, 123
v. George's, 123
v. Icarus, 42
v. London Hospital, 81
v. Royal Holloway, 437
v. St. Thomas's, 81
v. U.C.H, 436
SOCIOLOGY: Unit of, as applied to Medicine [Freshers' edition] (D. Armstrong), 384
SOUTH WALES AND MONMOUTHSHIRE GUY'S HOSPITAL SOCIETY, 5, 142
SPECTOR, R. The Department of Pharmacology [Freshers' edition], 385
SPIRA, M. *How to lose weight without really dieting*, 511 (R)
SPIT, 119 (C), 454 (P)
SPORT, 41, 78, 120, 168, 217, 260 (C), 264, 348, 366, 373 (P), 431 (C), 433, 515 (C), 518
Honor Oak Park bar, 38(C), 76 (C)
SPRAWSON, Evelyn, PRIZE, 460
SQUASH CLUB, 260 (C), 523
Cambridge tour, 173
Ladies' squash, 523
Inter-hospitals tournament, 267
new courts, 323
STAFFORD-CLARK, D. *and* SMITH, A. C. *Psychiatry for students*, 214 (R)
STANDRING, G. L: Appointed area dental officer, Greenwich and Bexley A.H.A, 273
STEEN, E. B. *Abbreviations in medicine*. 4th edition, 514 (R)
STOKES, Adrian, MEMORIAL FELLOWSHIP, 175
STOTT, R. Health care in China, 62
STRIKER, G. E. *et al. Use and interpretation of renal biopsy*, 263 (R)
STUDENT MEDICAL EDUCATION COMMITTEE
committee 1978, 527
election, 418
medical curriculum, 501
The new clinical course: a survey, 254
questionnaire on the clinical course, 4, 55
relationship with Clubs' Union, 54
STUDENTS: Examination pass rates, 273 (P), 363 (C)
grants, 180
selection, 38 (C), 515 (C)
STUDENTS' BAR, 8, 52, 119 (C), 129 (P), 137, 215 (C), 260 (C)
Students in general practice: the third of four papers presented to the 4th annual meeting of G.P.s and Hospital Consultants of the Guy's Health District (P. M. Higgins), 108
SUMMER FESTIVAL AND SPORTS DAY, 48, 87
results, 265
Surgery—too little, science—too much (F. Ellis), 476
SURGICAL FIRMS: Rearrangements, 323
Surgical firms outside Guy's (D. Denning), 365 (C)
SWIMMING CLUB, 124
Orchard Lisle swimming pool, 228, 377
staff v. students match, 521
U.L.U. swimming gala, 43

T

TAYLOR, Jane: Awarded Evelyn Sprawson prize, 460
TAYLOR, M .W. B: Death, 91
TAYLOR, N. Apathy! 260 (C)
TAYLOR, R. W. *and* BRUSH, M. G. *Obstetrics and gynaecology*, 509 (R)
TELEVISION REVIEWS, 354 (R)
TENNIS CLUB, 260 (C)
THAMES FLOODING, 6, 49
THEATRE REVIEWS, 210 (R), 252 (R), 307 (R), 352 (R)
Third World comment [on hospital expenditure in the western world] (S. Loman), 432 (C)
THOMAS, H. F: Appointed assistant professor, department of Pediatric Dentistry, University of Texas, San Antonio, 275
THOMAS GUY SCHOOL OF NURSING: Pass lists, 371
scholarship, 451
The threat of fascism (C. Brooks), 77 (C)
TILLEY, R: Obituary, 229
TIMBURY, M. C. *Notes on medical virology*. 6th edition, 115 (R)
TITLEY, Linda R. S. Professor Haslewood—a refreshing reply, 515 (C)
TOWER. *See* GUY'S TOWER
TREASE, G. E. *and* EVANS, W. C. *Pharmacognosy*. 11th edition, 164 (R)
Treatment contracts at the York Clinic (B. Rosen), 157
Tuberculosis in the community: case reports (R. M. Turner), 249
TUDDENHAM, D. Occupational medicine, 312 (C)
TUDGAY, B. A. What is wrong with the N.H.S? 76 (C)
TURK, D. C. *and* PORTER, I. A. *A short textbook of medical microbiology*. 4th edition, 425 (R)
TURNER, D. R. The Department of Pathology [Freshers' edition], 385
TURNER, P. *and* VOLANS, G. *The drugs handbook*, 214 (R)
TURNER, R. M. Acute confusional states: three cases from general practice, 250
Tuberculosis in the community: case reports, 249

U

UNDERWOOD, T. A. *and* UNDERWOOD. K. O. Boland House blues, 119 (C)

V

Vaccination against dental caries (S. J. Challacombe), 58

W

WARNER, E. Pullen-. *See* PULLEN-WARNER, E. *and* L'ESTRANGE, P. R, 512 (R)
WARWICK, R. On learning [Freshers' edition], 381
WATER POLO CLUB
Ladies' water polo, 522
tour 1978, 434
United Hospitals league, 521
University of London knockout tournament, 521
WATSON, T. Playing trains or modelling railways? 17
WEBB, F. *jt. author. See* BLONDSTEIN, I. *and* WEBB, F. 316 (C)
WEBB, P. *Art and pornography*: address to the Quodlibet Society, 140
WEDDUP, J. E. C: Appointed chief preventive dental officer, Bermuda, 323
WEINMAN, J. B.M.S. Psychology as applied to Medicine [Freshers' edition], 383
WEIR, D. M. *Immunology: an outline for students of medicine and biology*. 8th edition, 75 (R)
WEIR, J. *and* ABRAHAMS, P. *An atlas of radiological anatomy*, 426 (R)
WEISBERG, L. A, NICE, C. *and* KATZ, M. *A text-atlas of cerebral computed tomography*, 362 (R)
WESTBROOK, Ethel M. *See* PUGH, Doris E. *and* WESTBROOK, Ethel M, 39 (C)
WHEELER, S. J. Candidates for medicine? 38 (C)
The whole-body scanner in clinical practice (J. de Winter), 289
WILLIAMS, A. [Piper's painting of old Guy's House: colour prints], 365 (C)
WILLIAMS, D. E: University of London special lecturer on Human Communication and the Problems of Stuttering, 323
WILLS LIBRARY: The questions you ask us [Freshers' edition] (Jean Farmer), 386
WINTER, J. de The whole-body scanner in clinical practice, 289
Women and drugs (Sue Barlow), 240
WOOD, S. A broader view [What is wrong with the N.H.S.], 76 (C)
The working mother (Tania Phillips), 233
WORKS DEPARTMENT: Fire, 374
WYARD, S. J. The physical basis of CT scanning, 281

Y

YAFFE, M. Edmonton 1978: psychology and the superior sportsman, 348
YORK CLINIC: Treatment contracts (B. Rosen), 157
YUDKIN, J. *The drug companies and health*: [address to the Issues in Health Group], 98

Published by the Committee of Guy's Hospital Gazette and
Printed by BOSP Print Limited, Beeline House, Farwig Lane, Bromley, Kent

GUY'S HOSPITAL GAZETTE

ISSN No.: 0017-5870 Tel. No.: 01-407 7600 Ext. 2023

EDITOR STEPHANIE A. AMIEL
ASSISTANT EDITOR RICHARD HENDERSON
NEWS EDITORS A. P. J. PINI, R. DOBSON, S. FENNY & P. J. RAZZELL
NURSING CORRESPONDENT Miss P. M. JEFFERIES
PHYSIOTHERAPY CORRESPONDENT R. J. COOPER
RADIOGRAPHY CORRESPONDENT J. GUEST
MANAGER L. PAYNE

MONTHLY 28 JANUARY 1978 VOLUME 92 NUMBER 2278

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

How real is the threat of fascism?

It is often said that Sir Oswald Moseley's brand of fascism never became established in this country because like any other form of extremism it was repugnant to our senses of decency and democracy. While I think that this is essentially correct the rapid and therefore spectacular demise of his movement probably had more to do with the need for coalition during the last war than with indignant revulsion. That fascism is a doctrine of method and not a political ideology is not always readily appreciated and especially not so by those who advocate,"fascists unite"! Traditionally fascism has appealed in times of economic stress because it offers catch-all solutions, its technique is simple; pick an easily identifiable minority, blame it for the ills of the world and thus satiate the masses by allowing them to vent their aggression on the lowest member of the caste. Naturally enough at the pinnacle of the hierarchy required to co-ordinate this discontent sits none other than World Leader, who is usually a striking figure possessed with rousing, infatuating powers of oratory and a perverted sense of altruism.

The John Kingsley Read trial aroused a great deal of ballyhoo concerning the right to hold opinions and speak freely and of the dangers of racism and the National Front. Many commentators are worried that racism, under the guise of patriotism, is becoming so divisive as to threaten society while the National Front is regarded by some of them as the thin end of the wedge of disorder. I think that much of the commentary in the media has been somewhat hysterical (probably in an attempt to do better business) since it has ignored the priming conditions for the growth of fascism. We are not gripped by an economic catastrophe and nor are there any suitably small immigrant groups who would serve the racist's purpose. At the risk of sounding priggish I suspect that Read's comments served only to "outrage" the Parliamentary Labour Party along with a few race relations "experts" and did more damage to a judge than to racial harmony.

It may be the case that the law was not offended but taken in the context of a relatively newly multi-racial society Read's remarks were certainly unpalatable to some. But just how free is anyone to insult his contemporaries, albeit within the law? Anti-social types are quickly ostracised from a moderate society whatever its ethnic composition and there is not the slightest scrap of evidence that we have become less tolerant over the last twenty years. I should think that the opposite is true.

Publicity which sensationalises aspects of race relations is quite out of proportion to the fact that society is as decent and democratic now as it is ever likely to be. The National Front will have won a victory indeed if it is ever unlawful to make socially (whatever that is held to be) unpalatable remarks.

Pupils' Physical Society

The Pupils' Physical Society is a Guy's institution that stubbornly refuses to be laid to rest. Every time the last nail is banged in the coffin a feeble tapping from within alarms the undertakers. This time resuscitation is being attempted by a group of predominantly first year clinical medical students anxious that the society should again live to "foster interest in medicine, surgery and allied subjects".

The Society is a direct descendant of the older Physical Society which was founded in 1771 and was London's oldest medical society. Another offshoot of this original society still flourishes at St. Thomas Hospital. At Guy's the Pupils' Physical Society has had an erratic existence since 1830—sometimes being a forum for the presentation of student papers, debates and symposia, and at other times existing only as a semi-forgotten name on the Clubs' Union accounts, mourned (prematurely) by the few. Nostalgic memories of debates by gaslight in the Medical School followed by beer and sandwiches are brought to mind.

But what of today? Has the Society got anything to offer to the students, whose clinical curriculum is jam-packed as never before? The organisers clearly think so. There is a growing feeling that recent changes in medical education have tended to encourage a functional rather than an enquiring approach to learning on the part of students; and intensive timetables, didactic teaching and ubiquitous M.C.Q. tests have tended to reinforce this view. Medicine is in danger of becoming a subject in which the student is instructed in the wisdom (or is it folly?) of the elders, and is all too seldom required to think for himself.

By providing a vehicle for the presentation of original work (B.Sc., paediatrics and community medicine projects for example) and debate on topical issues of professional interest the Pupils' Physical Society may well encourage a more active involvement by the students in their own education. If so we wish it well.

NEWS IN BRIEF

New Year's Honours List

We should like to offer our heartiest congratulations to the following Guy's men who were honoured this year: Professor William J. H. Butterfield, Regius Professor of Physic in the University of Cambridge—Knight Bachelor. Professor Sydney Cohen of the Department of Chemical Pathology and Professor Kenneth P. Liddelow, lately Dean of Dental Studies, at King's College Hospital—Commanders of the British Empire. Dr. Walter W. Cashmore, Commander Midlands Area St. John's Ambulance Brigade —Order of the British Empire.

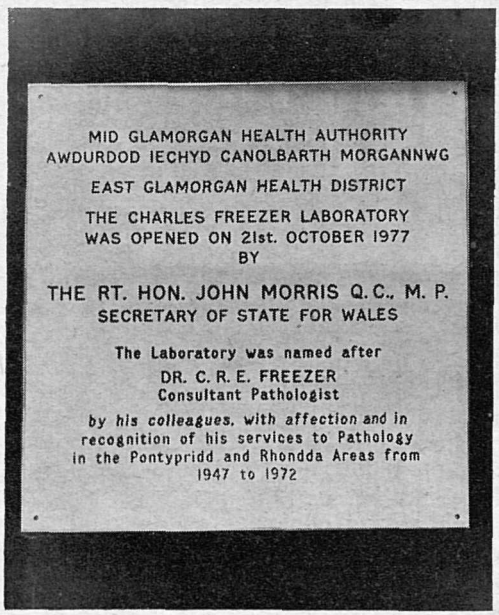
New Appointments

Brigadier W. J. Pryn, O.B.E., M.B., F.R.C.S., has been posted as Command Consultant Surgeon to the British Army of the Rhine.

Dr. Malcolm Forsythe has been appointed regional medical officer of the South-east Thames Regional Health Authority. He has been a member of the Resource Allocation Working Party and has worked extensively on the development of computer services in the N.H.S.

Dr. Christopher S. Darke has taken up the post as Chief Medical Officer with Private Patients Plan at Tunbridge Wells and, returning to the South-eastern Sector from Sheffield, hopes to see more of Guy's men and women in the future.

Dr. C. R. E. Freezer



We offer our heartiest congratulations to Dr. Charles Royal Ernest Freezer, who qualified M.R.C.S., L.R.C.P., in 1927 and M.B., B.S. (Lond.) in 1929, and has been honoured by having the New Pathology Department Building at East Glamorgan General Hospital named "The Charles Freezer Laboratory" after him. Dr. Freezer, now retired and living in Cardiff, was sometime Editor of the *Gazette* and a demonstrator in anatomy before the war.

Dental Clinical Day, 1978

As announced earlier, the Annual Dental Clinical Day will be held on Saturday, March 4th. The programme is printed on pages 22-23. Two thousand, three hundred and ninety application forms for Clinical Day and for the combined Dinner/Ball in the evening at Grosvenor House Hotel have been mailed to all alumni listed in the new Register. Anyone (student, staff or old Guy's man) who has not received an application form and would like to attend should contact Francis Collier (Honorary Secretary) or Colin Mitchell (Honorary Ball Secretary) on Floor 24, Guy's Hospital Dental School, London, SE1 9RT. Tickets will be mailed or cheques returned on February 10th. It is therefore important that applications are received as soon as possible.

"Past v. Present—Hockey"

This annual fixture will take place on Sunday, March 5th, 1978 at H.O.P. Would anyone who would like to play for the Past please contact Dr. Mike Appleby at 151 Chartridge Lane, Chesham, Bucks., HP5 2SE. Telephone Chesham 6407 (Home) or, Chesham 74855 (Work).

General Practitioner Meetings

Clinical meetings for General Practitioners are held at Guy's Hospital on the first Wednesday of each month in the Demonstration Room, Department of Neurology, Ground Floor, Hunt's House at 8.15 p.m. Coffee and sandwiches are available from 7.45 p.m. and there are facilities for doctors to receive phone calls.

Wednesday 1st February

Drugs in Cardiovascular Disease.
Professor R. Spector.

Wednesday 1st March

Problems of Genito-urinary medicine.
Dr. A. Grimble.

Wednesday 5th April

Obesity and its consequences.
Professor H. Keen.

Another questionnaire

The Student Medical Education Committee (S.M.E.C.) is at present debating the form of a questionnaire to be given to medical students who have completed their first clinical year. The proposed introduction states that "there has been controversy over certain aspects of the new clinical course, both among clinicians and students and this questionnaire concentrates on these areas! A brief glance at the proposed questionnaire reveals that these problem areas include the length of medical and surgical films, the place of specialities, the systematic lectures and of course the pathology block course. With 25 questions this questionnaire promises to be the most thorough so far. If the prospect of filling it out dismays you, spare a thought for those who will have to interpret the results!

Dates from the Medical Diary

Friday, 4th February—Entries close for the Charles Forster Prize in Cardiology.

Wednesday, 8th February—Examination for the Charles Forster Prize in Cardiology begins.

Friday, 10th February—Entries close for the Charles Oldham Prize in Ophthalmology.

Wednesday, 15th February—Examination for the Charles Oldham Prize in Ophthalmology begins.

Friday, February 17th—Entries close for the Gilbert Prize in Rheumatology.

Monday, 20th February—Entries close for the Final Conjoint Examination in April.

Wednesday, 22nd February—Examination for the Gilbert Prize in Rheumatology begins.
Examination for the Michael Harris Prize in Anatomy begins.

Thursday, 23rd February—Entry forms for the Preliminary Examination for Studies in Medical Subjects must be left in the Medical School Office not later than this date.

Friday, 14th February—Entries close for the Treasurer's Medal and Tewfik Prize in Surgery.

Dates from the Dental Diary

Monday, 20th February—Applications close for the Final L.D.S. Examination, Part II (Dental Prosthetics).

Thursday, 23rd February—Entry forms for the Preliminary Examination for Studies in Medical Subjects (obtainable from the Medical School Office) must be left in the Medical School Office not later than this date.

Tuesday, 28th February—Entries close for the Examination for the Newland-Pedley Medal and Prize in Operative Dentistry.

South Wales & Monmouthshire Guy's Hospital Society

Chairman : Mr. G. Morwent Brown.
Hon. Sec : Dr. H. Anthony Thomas, Greystones, Llysworney, Near Cowbridge, CF7 7NQ. (Cowbridge 4644).

The Twenty-seventh Meeting and Dinner of this Society will be held at the Park Hotel, Cardiff, on Saturday, 18th March, 1978 (7.45 for 8.30) following the Wales v. France Rugby International Match.

The President for 1978-79 will be Mr. R. F. Hoare.

All Guy's men and women are welcome. The tickets for the Dinner are £5.50 per head and the annual membership fee of the Society is £1.00.

It would facilitate arrangements if all those intending to be present would notify the Hon. Sec. and sent their remittances, payable to the Society, by Wednesday, 15th March, 1978.

New Cover?

Well, not exactly. In fact it is the old one done out in lurid red for the new year. It's not that we think that red is particularly appropriate for a hospital magazine, and to ascribe political significance to the choice of colour would—we hasten to add—be misleading. It's just that it makes a change from the nothing-in-particular grey of the past couple of years. But don't be alarmed; a completely new cover is at present being designed for the *Gazette* in the Department of Medical Illustration, and this will be ready for the summer.

Nearly a fire

Fourteen *Green Goddess* fire engines and nearly 100 soldiers fought a raging fire in a disused warehouse near the hospital on January 7th. The fire, in Southwark Street, showered sparks across the hospital, but the situation was brought under control in about an hour. One off-duty Guy's medic performed a heroic deed in removing a splinter from a soldier's eye, and the medical take-in firm should also be praised for their calm confidence in stamping out stray sparks.

Nearly a flood

That flood warning Guy's has been dreading came on the night of 11th January, when the River Thames was within inches of overflowing its banks in Central London. The hospital is sited in a high flood risk area and the danger period will last until March or April. We hope to inform our readers of the hospital's preparations for flooding in our February edition.

Rugby Club Reunion Weekend

The rugby club annual reunion weekend will take place on February 4th - 5th. A dinner-dance will be held at 7.30 p.m. in Boland House (E. Wing) on February 4th and the Past v. Present match at 2.30 p.m., February 5th, Honor Oak Park. For further information contact Dr. S. Challacombe, Dept. Oral Immunology, Guy's.

Austerity at the R.C.P.

Sir Cyril Clarke sent us this reminder of the squeeze, taken when he was President, about a year ago.

(Photo by courtesy of the Royal College of Physicians)

Friends of Guy's Christmas Stall

The Christmas Stall held in the Colonnade raised over £600 for "The Friends of Guy's", and we should like to express our thanks and appreciation to all who supported us so well.

On Thursday, 9th February 1978, Robin Ellis and Pam Furlong are presenting a Scottish Evening in the Greenwood Theatre. Tickets are available now from the Services Branch office at £2.00, £1.50p and £1.00.

Various artistes well known to the Scots in the South East are taking part and Gordon Jackson has agreed to make the draw for the Lucky Programme. All profits are for "The Friends of Guy's Hospital".

Keats-Shelley Memorial Appeal Fund

The Council of Governors of the School have donated £250 from the School to the Keats-Shelley Memorial Appeal Fund which is currently appealing for £30,000 to save the Keats-Shelley Museum in Rome.

The Museum occupies the room in which Keats lived during his final illness, after he left England in September 1820 to seek the Italian sunshine, until his death in February 1821. The house and Keats' grave were saved from destruction by developers in 1903 and the house became a museum. It is threatened now by the expense of increased rates and the inadequacy of an income which is limited by rent restrictions. The story was told by James Lees-Milne in Country Life on 15th September this year.

To date the appeal has raised in the region of £17,000.

CLUBS' UNION NEWS

Once again, February is upon us, and with it the Annual General Meeting of the Union. This is the happy day when I finish my duties as President, along with all the other current Union officers and, rather like Old Father Time passing on, the fresh, new Union executive assumes power. The new President and Vice-President will be David Denning and Phil Carney and by the time this article is published all the other officers will also have been elected. I wish them well, for there is much to be done and I hope that you will all make some effort to support them throughout the year.

Attendance at A.G.M.'s

It is most important that you do attend the A.G.M. even if this is the only occasion when you actually manage to attend a General Meeting. It will be held on February 14th at 1.00 p.m. in the Ballroom. As well as electing your representatives to the various committees, (Entertainments, Bar, Catering and Hostels) it is an opportunity to discuss what the Union has been doing during the last year, and what you would like it to do during the next year. Just two of the things that will be considered are the setting up of a Union Shop, and the Union employing a part-time administrative secretary to help with its day to day running. Incidentally, if any of you are interested in helping with a Union Shop please contact me as we shall need all the help we can get! If you wish to raise any specific points at the meeting it would help if you could let us have them in writing at least eight days beforehand.

Pushbutton Beer

There has been much unrest about the new "measured pint" system recently installed in the bar and this merits some explanation. The bar has been showing a shortage in each month's figures for some time. The Bar Committee has a responsibility to the Union and to some extent the Medical School, to run the Bar, and this obviously involves looking after the finances. In an attempt to cut down on "Guy's Halves" and other wastage, the committee took the decision to install the new system. The decision was taken only after a great deal of thought and a close watch of the situation over a period of months. Many people will argue that the amount saved could not possibly justify the expenditure, but it is very surprising how much money could be lost over one month just from "Guy's Halves" etc.

Frequenters of the bar will have realised that the system has had a lot of "teething problems" and this has possibly annoyed people even more! However, I am sure that once the problems have been ironed out, people will not be worried about the system, as the beer will be just the same as it was before.

Whilst on the subject of the bar, a recurrent problem throughout the year has been vandalism. It is not news to say that some people get very high spirited from time to time and of course we all expect this (and are probably also guilty of it!). However it has to be said that some people are so thoughtless and irresponsible in their actions as to make one wonder how to deal with the situation. The Medical School has from time to time suggested that the Bar should be closed on the next night. While this point of view is very understandable, it would not achieve anything. The problem is for us all to try and sort out in any way we can. If this means suspending people from using the Bar, then this must be seriously considered.

N.U.S. Health Student Conference at Loughborough

In accordance with Union policy, Phil Carney and myself attended the annual N.U.S. Health Student policy conference as observers at Loughborough University on January 7th and 8th. It is not easy to give a full account of what went on in the space available here, but I have tried to set out a potted account of some of the more important topics discussed.

Grants. The topic of grants was discussed at length, with particular attention to the anomalies which we face, such as the inadequate "long course" clinical grant and the inadequacy of the special equipment grant. Motions were passed on these issues so that these anomalies will be pointed out and included in N.U.S.'s negotiations with the D.E.S. at future grants reviews.

Pre-Reg Jobs. N.U.S. H.S. Medics Working Party met with Drs. Lowe and Brothwood who are on the D.H.S.S. Working Party on Pre-Reg Jobs. It was reported that they have instructed the Regional Health Authorities to increase the number of jobs to cater for the increased medical student numbers. It remains to be seen how and if they will do this, but this is the first good news on what is potentially a very serious situation. It is important that complacency does not now set in on this issue, as these increases (by the D.H.S.S.'s own admission) will need careful monitoring.

Dentists. At present dental students have no N.U.S. working party, probably because of the B.D.S.A. A motion was passed instructing the executive to investigate whether dental students would like such a working party. B.D.S.A. and any N.U.S. H.S. Dental Working Party need not be incompatible as is often supposed, and this is a subject that we must consider at General Meeting, for despite the fact that we are not affiliated to N.U.S.

such a decision would affect dental representation at all the 17 dental schools in the U.K.

Union Development. We had a long discussion about Union structures, how they may be improved, and the idea of integrated Health Student Unions, involving all Health Student disciplines including Nurses, Physios, Radios, etc. As is usually the case the exchange of ideas is probably more important than any motion which may be passed.

These are just some of the things discussed, and as always, much useful information was picked up in the bar. A couple of points worthy of a mention. Firstly, since the N.U.S. national conference in December, the Health Student Sector of N.U.S. is now officially one of N.U.S.'s "priority areas" in terms of expansion, development and financial backing. This is almost certainly due to the Sector's huge increase in activity over the last year or so. Finally, the pro-N.U.S. lobby may be delighted to hear that Sue Slipman (remember her?) now uses the Guy's E.G.M. in November as one of her anecdotes!

Francis Hughes.

OBITUARY

Thomas Gwilym Pritchard

On the morning of December 27th, 1977 following five years of illness, Thomas Gwilym Pritchard, L.R.C.P., M.R.C.S., aged 63, of Penygroes, North Wales passed away. A general practitioner at Penygroes since 1939 he had trained at Guy's from 1935, being one of the most promising students of his year; a demonstrator in the anatomy department and gaining his Primary F.R.C.S. as an undergraduate. Subsequently he was planning a course in surgery when he was called to deputise for Dr. Shelton Roberts of Penygroes who had fallen ill. Following the death of Dr. Roberts he agreed to take over the practice permanently. In the ensuing years he led a public life playing a leading role in most of the activities of the local community and being an active county councillor from 1956 to 1973. He leaves a widow Dr. Meira Pritchard (who continues with the practice) and two sons: John, a chartered accountant, and Hefin who is a final year medical student at Guy's.

The funeral was held in Penygoes on December 30th.

H.P.

Surgeon Captain A. T. Rivers, R.N.(Retd.)

We were saddened to hear of the death of Surgeon Captain Arthur T. Rivers who qualified on November 9th, 1906. He enjoyed distinguished service in the Royal Navy and retired from the service in 1935.

He served under two monarchs, King Edward VII and King George V, in a number of famous naval ships including H.M.S. Lord Nelson and H.M.S. Calcutta.

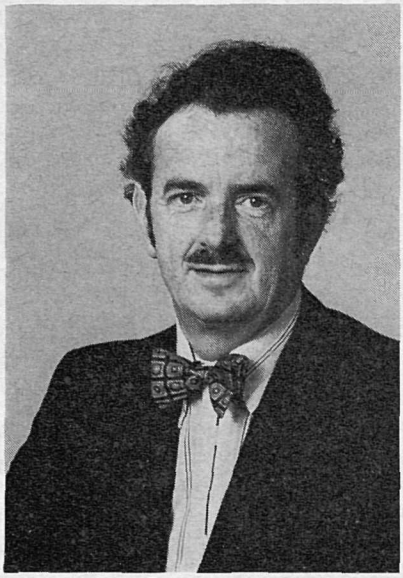
The funeral service was held at Cardross Crematorium and at the Captain's request it was conducted by a naval chaplain.

The Church of England chaplain at the Clyde Submarine Base, Faslane, the Rev. Arthur Nunnerley, was accompanied at the service by the present principal medical officer, Surgeon Commander John Bough.

The captain's closest relative, Group Captain David Moffat, R.A.F., attended the service with close friends, to whom we extend our sympathies.

GAZETTE INTERVIEW WITH
Prof. A. T. DIPLOCK, D.Sc., Ph.D.

Philip Razzell interviewed the new professor of biochemistry just before Christmas.



Gazette: Professor, would you outline your career in biochemistry?

Diplock: Certainly. I started at Bristol University. I had always wanted to do a degree in biochemistry, but unfortunately the course in those days had a fairly limited entry and I was unable to get in. They offered me a degree course in physiology with a subsidiary in chemistry, which I did. Having obtained that degree in 1956 there was a suggestion that I might stay on and do a Ph.D. at Bristol, but I had just met the lady who was subsequently to become my wife. We decided that we wanted to get married and that I wouldn't stay on but get out and earn some money.

I took a job in industry, working for a company with the remarkable name of Vitamins Limited, which had interests in pharmaceuticals and agricultural feedstuffs. I went to work at their research station at Tadworth, Surrey. At the time I arrived in 1957 they had recently developed an industrial process for making Vitamin E from vegetable oils, and they set me to the task of attempting to discover the mode of action of Vitamin E in animals. Really I can say I am doing the same thing now; I have been working on it ever since! The great thing so far as this job was concerned was that we were able to publish all the work we did and this gave my career the most marvellous start.

During the period of 10 years that I was there I began to regret the fact that I had not done a Ph.D. because getting much further obviously depended on having a higher degree. It was in 1959 I think, that I met for the first time Professor Haslewood and got talking to him about this problem. With characteristic generosity he said, "well, why don't you do a Ph.D. part-time under my supervision?" This was a tremendous offer, but we then found that the London University regulations were such that it was not possible for me to do a Ph.D. in the way we proposed because I was a Bristol graduate. Professor Haslewood was quite undaunted by this and took on the whole Establishment, as a result of which new regulations were introduced and I did my Ph.D. here at Guy's under his direction.

At the end of the period in industry in 1967 I began to feel that I would like to return to academic life. I started applying for lectureships and eventually I was appointed to a lectureship at the Royal Free Hospital School of Medicine in the Biochemistry Department. I shared an interest in fat soluble vitamins with Professor Lucy there and we collaborated together on research, publishing quite a number of papers on vitamin E and related topics. My interests gradually became more diverse, I was appointed Reader in the same Department in 1973 and I was successful in getting the D.Sc. of the University of London in 1976.

Gazette: Can you say a bit more about your current research interests?

Diplock: I've maintained my interest in Vitamin E as well as other fat-soluble vitamins. Perhaps I should say that Vitamin E is inter-related with Selenium, acting as a trace element, and I really think it is impossible to work on one without the other as functions of the two nutrients are so closely bound up together. More recently I've been interested in the interaction of Selenium with other trace elements like mercury and cadmium, with all that that implies in the general field of metal toxicology and environmental pollution.

Gazette: Does your research on Vitamin E have any clinical applications?

Diplock: Well, in some respects it does. A lot of the applications of my work are in veterinary medicine rather than human medicine—Vitamin E and Selenium deficiencies are quite major problems in agriculture.

So far as human medicine is concerned Vitamin E has classically been regarded as a universal panacea and there are reports of Vitamin E being beneficial in almost every disease-state you care to mention. However, the *established* effects of Vitamin E in man are very limited indeed; it has been used successfully in treating the haematological disorders of the premature newborn infant and Vitamin E, in pharmacological doses, can be used in the treatment of intermittent claudication. These are really the only two reliable instances of Vitamin E being involved in human medicine.

Gazette: Do you think that a biochemistry department within a hospital has an obligation to do research on subjects of clinical interests?

Diplock: No, I don't think so at all, in fact I would rather take the opposite view. I believe that freedom to do research into topics that interest one is fundamental to members of academic staff in a university

department such as this. I would be very loath to indicate to a member of staff what he or she should be interested in from a research point of view. As soon as pressure to do research in a particular area was brought to bear, recruitment would suffer and the best people would tend to go elsewhere.

Gazette: What advice would you give to someone starting off in research?

Diplock: That's a very difficult question! One of the most difficult things in research is being willing to admit that one is wrong. This is probably a basic principle in life as a whole, but particularly in research one has to have the ability to keep a very open mind. Even if you have a great emotional involvement with a particular line of thought you have to be more than ready and willing to admit that that line of thought may be wrong. It's often a very difficult thing to accept.

Gazette: In what areas do you find particular pleasure in your job?

Diplock: First and foremost I think it's in the contact with people and particularly the contact with students. I derive a tremendous amount of satisfaction from teaching and other contacts with students. This is something I enjoy very much and I would put this pleasure first. Coming closely behind that I would put the pleasure I derive from doing research and perhaps being able occasionally to make an interesting discovery.

Gazette: So you enjoy working with students?

Diplock: Yes, indeed I do, both professionally and socially. I wonder whether it might be appropriate to mention the sort of student activities I have been involved with at the Royal Free? First of all I have been Treasurer of the Students' Union for the past four years, which has meant a very considerable involvement in time. One of my most arduous duties was running the financial side of the students' bar and this has been a very problematical and difficult task to accomplish. We've had our good times and our bad times. Sometimes money and bottles have disappeared with startling speed, but there have also been times when we succeeded in making a profit!

In addition to that I have been an informal advisor to students—appointed really at the request of the Students' Union. This particular job arose some eight years ago when we had an unhappy situation with one student that none of the staff, or indeed other students, were aware of. As a result of this the then President of the Union entered into discussions with me as to how we could attempt to cover the problem of student welfare. The kind of situation I'm talking about is students who are depressed and unhappy, and maybe—as sometimes happens—suicidal. The sort of problems that arise are for example very often boy-girl situations; the need for advice on contraception, and also the need to give advice on pregnancy. These are just some of the kinds of problem that need sympathetic handling.

I have spent a great deal of time endeavouring to help students in the sort of situations I've mentioned. I think it's been a rewarding investment of time in that there are a number of people who are now qualified and happy, fulfilled doctors who have gone through a difficult period at some time during their student life.

Gazette: Do you envisage playing an active part in teaching at Guy's?

Diplock: Yes. I don't believe in "sleeping" professors. The head of a department should be seen to be playing a very active part in teaching all the way down the line. I don't see the professor as a kind of figurehead in a department.

Gazette: Are you happy with the present form of the preclinical B.M.S. biochemistry course?

Diplock: Well, what do you mean by the present form? Perhaps I should point out that there have been put into effect some fairly major changes in the B.M.S. course starting in October 1977. The members of staff had a very radical look at the B.M.S. course in the past year and have produced a scheme for a new course which has just started. When my appointment was confirmed they showed me this new scheme and I approved very much of the changes that had been made. I think we should regard it as only being a start; a move in the kind of direction I would like to see the B.M.S. course evolving.

Gazette: How do you envisage a B.M.S. course in biochemistry?

Diplock: I really think the most important feature is relevance to medicine. I have found from teaching experience that it is this one feature of relevance to subsequent clinical work that counts; which is why, after all, students come to medical school. I would take this as my first principle and my approach to the course is to attempt to see an overall picture in metabolic processes. Obviously in order to understand metabolism one has to go into detail about individual metabolic pathways and so on, but there is so much of a danger with medical students that they get bogged down in the detail and fail to see the overall picture emerging. They become paranoid about learning particular chemical structures so that they can trot them out for exams, and in the process they completely miss the point of the whole exercise. My approach is to aim to run a course where students go away with an excellent overall picture of metabolism and how metabolic events are co-ordinated in the body, without over-emphasis on knowledge of the detailed chemistry.

Gazette: So this will involve both a change in the way that biochemistry is taught and the way it is examined?

Diplock: I think so in some respects, yes, but I would be very reluctant to give the impression that I want to make radical changes very quickly and I would be dismayed at the thought that rapid, drastic changes should be made; there are great dangers in doing that. Rather, I would like to see a gradual evolution of the B.M.S. course along the lines I've indicated.

Gazette: There have been a lot of complaints from students about biochemistry practicals; in particular that there are too many, that they go on too long and that they have little relevance to subsequent clinical work. Would you like to comment?

Diplock: This is an area that I certainly want to look at. I must confess that in the short while I have been here I have been more concerned with the lecture course and have tended to leave the practical course until later. Perhaps I could answer the question by indicating the way in which things have changed at the Royal Free in the past few years, because we've been facing the same

comments from students there. We have in fact cut back very dramatically on the amount of practical taught, so that they now have five two-hour practicals for two terms, and in the fourth term five all-day practicals which are intended to let students get their teeth into a particular topic or problem. We found that, with this reduction in the course, the quality of work turned in improved very considerably. Students have been much more motivated toward the practical, and in particular the longer sessions have been very successful because they give some insight into the problems of actually doing biochemical experiments, which may well stand students in good stead later on in their careers.

Gazette: In altering the preclinical medical and dental biochemistry courses will you be consulting with other departments in the Medical School and Hospital?

Diplock: I would like to be able to foster as much inter-relationship as possible between the Biochemistry Department and other departments in school and hospital. I think that there is nothing worse than departments becoming isolated from one another. Having said that I would presume that lying behind your question is the matter of integrated teaching. As a general principle, the more integrated teaching one can do the better, but there are very profound difficulties in running totally integrated courses. To take an example—if one is asked to integrate on the subject of "muscle" it may well be that the physiologists wish to look at the principles of muscle contraction quite early. However, it would be quite impossible to have any meaningful discussion of the biochemical basis of muscle contraction until such time as a lot of basic biochemistry has been dealt with first. That kind of difficulty arises all the way down the line when one tries to have fully integrated courses.

Going back to what I said at the beginning, I am anxious to explore any avenue in order to find points of integration and secondly I would like to have as much indication as possible from clinical colleagues as to what they think are important features of biochemistry that they would like to see particularly stressed in the curriculum.

Gazette: Will there be increased opportunities for small group tutorial teaching in the future?

Diplock: I come from an institution where small group teaching is the order of the day. It has its successes and its failures. Particularly it requires co-operation between students and the members of staff concerned, but so often, because of the pressures on students, they don't have much time to prepare for tutorials, so the tutorial becomes a sort of re-hashed lecture. Tutorials are also labour intensive and we have very limited staff resources. For these reasons we need to make haste very slowly and cautiously along the direction of introducing more tutorials.

Gazette: How important is biochemistry to the clinician?

Diplock: Well, in the sense that any disease must have underlying it some biochemical abnormality I suppose it is all important. The difficulty is that the biochemical basis of most diseases remains imperfectly understood.

Gazette: Does it influence the way the clinician should treat patients?

Diplock: I'm very reluctant to pontificate on this question because I'm not medically qualified myself—and who am I to tell a clinician how to do his job? Off the cuff, I would have thought that the more the biochemistry underlying a disease state is understood the more successful treatment is likely to be.

Gazette: Coming from the Royal Free what do you think is the role of women in medicine?

Diplock: Well, I think they have a major part to play—I would not want to discriminate at all. It's often said that there is a danger that a girl, once she is qualified, will get married, settle down and have children, and that the large financial investment in her will have been wasted. I don't think that the official figures bear this out. Generally speaking women may take some time off while they have a family, but they usually come back to medicine when the family gets a little older. I think that women have a place in areas of medicine but there are certain areas where women have a particular role to play—for example in paediatrics, and of course in family planning clinics.

Gazette: When you are not being a biochemist how do you spend your spare time?

Diplock: I have four main outside interests. The first is sailing. I have for a number of years now had boats of various kinds. I had first of all a 4-tonner and then an 8-ton Hilliard sailing boat which we used to keep down in Chichester Harbour. The trouble with the 8-tonner was that it was costing us such a fortune to keep the wretched thing afloat that I was beginning to feel that we were not getting value for money. Because of this there was a tendency to feel that we must go and use the boat at weekends during the summer and we almost felt guilty if we stayed at home! So we sold that boat after a lot of heart searching. Recently we were able to buy a cottage in Norfolk on the Broads with a mooring of its own and I've now got another 4-tonner. My second interest is black and white and colour photography—something that I share with my son; we do quite a lot of photography together. Thirdly, I have a great interest in music, particularly in opera, and fourthly, I collect books, especially antique ones.

Gazette: Can we expect your participation in the students' sailing and photographic societies?

Diplock: By all means, yes, the only proviso, of course, being the availability of time. I was, for my sins, the Commodore of the Sailing Club at the Royal Free, but we didn't have a photographic society.

Gazette: Finally Professor, what do you think of Guy's?

Diplock: Of course I have not yet got used to being here full-time, but I like Guy's tremendously. I find that it has a kind of stability about it which appeals to me. This is probably because the Royal Free has been going through a period of great upheaval in recent years associated with the rebuilding of the hospital at Hampstead, and the projected move of the preclinical departments up to Hampstead as well. Coming to Guy's it is a welcome relief to find that the future looks reasonably assured.

Gazette: Thank you Professor.

LONDON BRIDGE STATION— MOVING WITH THE TIMES

Gazette News Staff

Many of our readers have, at some time in their lives, commuted in to London Bridge Station to begin their work at the Hospital. In the evenings they have wearily boarded a train there to return to their digs in Catford, semis in Orpington or mansions in Sevenoaks, according to their station. For present day commuters the reconstruction work now in progress is a matter of continuing interest, if only to find out when water will stop pouring through the canopies on rainy days and pneumatic drills cease to shatter their nerves.

A blend of old and new

British Rail estimate that the job will be finished by the end of 1979, by which time the canopies and buildings on the platforms will have been rebuilt, together with a new terminal concourse with shops, restaurant, ticket office and travel centre. The yellow geometrical spider that is at present advancing over the windswept bus terminal is the skeleton of an overall roof which, when completed, will enclose the entire area as far as the entrance to the Underground.

Mr. Clark, B.R.'s project manager, thinks the rebuilding will be a great improvement for the 53 million passengers who use the station each year. The old high-roofed terminus will remain, wedded to the new buildings. This gaunt, muscular remnant has been mauled by a century of continuous use, the Blitz and the rebuilding programme, but it is still an impressive building and it's a pity that travellers are seldom in the mood to appreciate it. "Never mind the wind, look at the architecture" is a piece of advice that B.R. would hesitate to give passengers! Mr. Clark explains that nowadays there is no requirement for a high roof in modern stations handling electric trains; they were designed to allow steam to disperse from waiting locomotives, but the terminus has happily been reprieved for a mixture of financial and conservation reasons.

History

London Bridge is a station with a long history; it was originally the terminus of the London to Greenwich Railway—London's first—and was opened with enormous ceremonial on December 14th, 1836.

The Lord Mayor of London "with his attendants" rode across London Bridge to do the deed and the bands of the Scots and Coldstream Guards played on the "beflagged and carpeted platform". The Lord Mayor and Sheriffs rode as far as Deptford in the first train, "with people crowded on the rooftops and upper windows every mile of the way and the bells of the churches ringing out as if it were a Royal occasion". Deptford was as far as the new railway went for its first two years, but before the end of 1838 it was extended to Greenwich. Within another year London Bridge station was being used by the London and Croydon Railway and, a little later, by the South Eastern Railway, which served the new lines branching out into Kent. Another early railway company to use the new station was the London and Brighton, who built their own platforms apart from those of the other companies and in 1851 "completed a handsome new terminal building with improved passenger facilities, just in time for London's Great Exhibition in Hyde Park". By this time the terminus as we know it today was largely established.

New footbridge for Guy's

Finally, an aspect of the reconstruction work which will be of interest to Guy's commuters is a proposed steel bridge connecting the station to the hospital and spanning St. Thomas Street. This is a joint project between the developers of the Southwark Towers complex and Guy's Special Trustees and, if legal agreements are settled, work could begin on the site next month. If so the prefabricated bridge could be erected by the end of April and, after paving and lighting work, might then open in May. If so spare a thought for the busker who performs each Friday on the steps from the station to the hospital—for him our new bridge could spell economic disaster—unless he too decides to move with the times!

The Guy's Hospital Gazette would like to thank British Rail for their help in the preparation of this article.

PLAYING TRAINS OR MODELLING RAILWAYS?

Tim Watson

Outside Guy's — continuing the series in which people explain the fascination they find in their hobbies.

Playing with trains, or "model railways" as some people prefer to call them, is one of my main interests. Most young lads' enthusiasm for a train set usually lapses; this is not always the case. Evidently, some people never grow up because they still have a "train set" when they reach their regulation three score years and ten. I must belong to the last category because, so far, my enthusiasm for model railways does not seem to have waned.

The railway modellers' diverse hobby tends to make him a "Jack of all trades" and, hopefully, master of a few. As an example, what other hobby can combine a fascination for mediaeval church architecture with a knowledge of solid state electronic chips? My outlook on model railways splits into three categories: research, modelling and social.

Research

Many people may not be aware of the fact that to make a convincing model requires an extensive knowledge of the way the original was built, whether by man or the Grand Designer. I suppose that in the last case, modelling a complete scene appeals to the megalomaniac in all of us. It is useless to put 3,000 tiles on a model cottage without first of all finding out why they are laid the way they are on the original. To this end, one has to find out how the supporting roof structure was made in the first place; if your model is to have a sagging roof it must sag in the right places. Similarly, an understanding of geology and agrarian practices will impart a fundamental realism to a scene. As you may have deduced, my interest does not stop at the railway boundary; it is always my aim to produce a model of the chosen railway in its geographical and historical context; i.e. accurate modelling of the countryside it runs through. Models of railway subjects require equally extensive research. I have spent hours looking at drawings, photographs and books before starting to make a locomotive. Even assuming that work has started on the model, research is required to find out the best motor design, the most convenient means of transmitting the drive, or simply how to make a particular type of wheel.

Modelling railways has taught me never to give up on a problem; people have often said, "You must have tremendous patience". It is really more a case of determination to see a problem through. On reflection, it is probably the development of new techniques that most appeals to me with model railways.

Modelling

The scale I have chosen to work to does not make it easy to produce good models. This scale is 2mm : 1 foot, thus a six foot man is just under ½in tall. (The most popular scale in this country is 4mm : 1 foot.) A whole spectrum of materials, from wood to gold, are used to produce the desired effects. It has often been said that a good model should be like a three dimensional painting, and for scenic modelling this is highly desirable, but for something as clearly defined as a locomotive "watchmaking" is perhaps a better aim. It is very satisfying to build something like a locomotive from sheets of metal, with each subsequent component leading to something more and more like the original. Accuracy is clearly a prerequisite to produce a convincing model, but with each new project new techniques are learnt or developed which makes construction that bit easier.

Social

When I first came up to London four years ago I joined The Model Railway Club and from this organisation I met people from all over the country and abroad. The amazing thing about model railways are the different types of people it involves. When I was playing with my Hornby train set I scarcely dreamt that it would lead to my knowing a violinist in the London Symphony Orchestra, the manager of a City bank nor yet a policeman from Carlisle. Everyone in this hobby is more than willing to give friendly advice and criticism. What's more, most meetings end with the downing of a few jars in the local.

I hope that I have given some of my reasons for following a hobby which is, after all, only "playing with trains"!

Come and see

I will be putting on a display of some of my models at the Dental Clinical Day on March 4th. If anyone would like more information on the subject as a whole please contact me via the pigeon holes on floor 24 of the Dental School.

THE DENTAL REVUE, 1977

"The Faulty Tower"

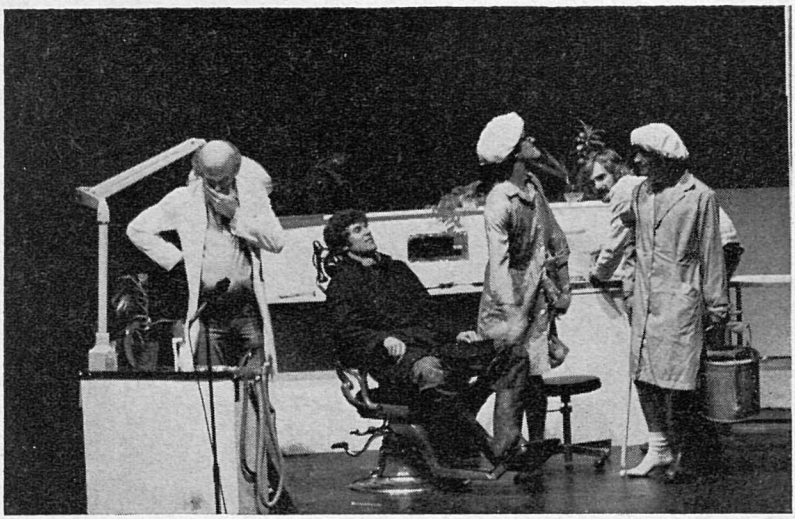
The period immediately following the Final B.D.S. Examination was one of feverish and secretive activity by the final year students. This culminated in the presentation of the Christmas Revue on 19th December which was played to a packed audience in the Greenwood auditorium. Many of the dental staff had been allocated tickets for the front rows and awaited the production with some trepidation to find out which of their particular foibles were to be explained in great detail to the assembled company. In the event all groups of staff were exposed, literally in some cases, to those present.

Most of the departments in the School were dealt with as the subject of a separate scene introduced by the "Vipers Chorus". The dress for the mixed chorus was outsize rugby shirts and shorts or tights with an assorted variety of footwear. The charm and beauty of our senior girls were unfortunately camouflaged by this garb.

The Primary Treatment Unit was shown to be firmly under the control of a larger than life senior D.S.A. The sporty camaraderie prevailing was not impeded by a patient who had been waiting for many hours with toothache whilst urgent attention was received by the city gentleman with a large

American Express card. During the scene one of the vital statistics of the D.S.A. collapsed with a loud report.

The scene about the Conservation Department entitled "A Bridge too Far or Next Patient Cleese" was dominated by a John Cleese-like figure who stormed about the stage. Helpful advice about treatment planning was offered by a senior student whilst some of the demonstrators were portrayed as rather loud and unsympathetic characters. There was the usual heartrending account of the vast amount of work that had to be completed. Two senior members of the Department were shown as sloppy chairside orderlies complete with buckets and mops and full of moans about their work. Of course one of them had a dark moustache.



A senior student contemplates the correct diagnosis. The cleaner's work was all in vain.

The Prosthetic scene was introduced by the Vipers' song "Compo Rim" and opened showing the Professor in bowler hat, white coat and Wellington boots conducting an inaudible clinic. The well-known member from the Emerald Isle added gaiety and humour to the scene. Three "technicians" presented a very amusing song called "Three Old Maids from the Lab".

After the interval the action took place in the Oral Surgery Department. It was a skit on a well-known TV programme renamed "Going for a B.D.S.". The experts on the team were introduced as Dr. Has Binnie and Mr. Bret Four Times a Day. Amongst the objects to be identified was an attractive student who had to submit to close examination!

The central figure in the sketch "Eileenabethan Times" portraying the Children's Department was the consultant paedodontist who as Queen Elizabeth I ruled her courtiers (fellow members of staff) with a stern hand. The song "My Way", sung by Ian Litchfield, received a tremendous ovation for his skilful presentation and mimicry.

The last scene "Beyond the Flap" took us to Floor 21, the Department of Periodontology and Preventive Dentistry. The most entertaining part of this excellent scene was a duologue in the style of Peter Cook and Dudley Moore between Ian Litchfield and Pete Rosie. This had the audience and the rest of the cast convulsed with laughter because so much was ad libbed.

Ian Litchfield (left) and Pete Rosie waiting for some Prevention.

The music for the show was provided by the Polly Sextet led by Pauline Arnold. The band never faltered in spite of what was happening on the stage.

It is difficult to single out individuals from the cast of thirty-nine, but the soloists deserve special mention; they were Robin Piper, Mike Attenborough, Brendan Hagan, Ian Litchfield and Howard Longton, who also wrote many of the songs. All who took part on the stage and behind the scenes are to be most warmly commended for putting an excellent entertainment together in such a short time.

At the end of the show Mark Harris, the producer, announced that the final year students wished to make the following awards. Dr. Ashley was voted the best teacher and was given a large plaster molar decorated with plaque, Mr. Mace was awarded a large teddy bear as the most popular member of staff and Mr. Bret Day was also given an award—for something to do with the Sex Discrimination Act.

The bruised egos of some staff members were rapidly soothed by an invitation from the final year students to a magnificent party in the Robens Suite. This made a fitting climax to a memorable evening.

A. H. R. Rowe.

Joys of Conservation—Howard Longton

When you wake up in the morning,
And you've got a throbbing head,
And you have a patient waiting,
But you'd rather stay in bed.
Do you phone up main reception,
And tell them that you're dead,
Or go revel in the joys of conservation.

Rowe and Cardwell,
Trickie Dickie too,
Tom Pitt-Ford,
They're after you.
And there's Mr. Brose,
Who's never got a queue,
As he revels in the joys of conservation.

And when it comes to finals,
And your points are rather sparse,
And you need six hundred plastics
And you need them very fast,
Do you tell Jack Rowe,
He can stick them up his . . . nose,
Or go revel in the joys of conservation.

Pick a Pocket or Two—Pete Rosie and Ian Litchfield

In P.D., life is fun,
Scaling teeth, and shredding gums,
Patients complain, horrendous pain,
When you pick a pocket or two,
You've got to pick a pocket or two,
You've got to pick a pocket or two.

We don't care if they are false or true,
You've got to pick a pocket or two.

When I make blood appear,
All the staff start to cheer,
Eager for more, they cry "Encore",
When you hack a pocket or two,
You've got to hack a pocket or two,
You've got to hack a pocket to two.

We don't care if they are red and raw,
You've got to hack a pocket or two.

Don't waste time, reading crap,
Use a knife, raise a flap.
Grind away bone, then send them home,
If you slice a pocket or two,
You've got to slice a pocket or two,
You've got to slice a pocket or two.

Don't send a wreath, they're only teeth,
You've got to slice a pocket or two.

PROGRAMME
ANNUAL CLINICAL MEETING
4th MARCH 1978

Morning Session: 9.30 a.m.–12.00 noon
Afternoon Session: 2.00 p.m.–4.00 p.m.

All Departments will be open but demonstrations by members of the staff will be on Floors 26 and 27 unless otherwise stated.

Lecture theatre (Floor 30)

11.00 a.m. Cases you have sent—Mr. R. Haskell.

2.15 p.m. Closed Circuit Colour Television Demonstration.

Cloakroom facilities on Floor 28.

Coffee will be available on Floor 23, 10.00 a.m.–11.30 a.m.

Tea will be available in Boland House (East Wing) from 3.45 p.m.

An Exhibition by members of the Dental Trade will be held on Floors 27 and 28.

DEPARTMENT OF CONSERVATIVE DENTAL SURGERY

A new composite (Fotofil)—Professor A. H. R. Rowe, Mr. M. L. Maberley.

Giving a local anaesthetic (Tape slide programme)—Professor A. H. R. Rowe, Mr. S. P. Johns, Dr. R. B. Johns.

Crown and Bridge Problems (Tape slide programme)—Mr. A. D. Robinson.

Some Dental Teaching Films—Mr. R. A. Ellis, Dr. D. Brown, Mr. B. D. Glynn.

Leakage of Root Filling Materials—Mr. T. R. Pitt Ford.

Sectional Amalgam Root Filling—The Dimashkich System—Mr. A. A. Robinson.

Display of Students' Work—Mr. M. Malleson, Mr. H. E. P. Grabaskey.

Application of Various Matrix Brands for Amalgam Condensation—Dr. M. O. Brose.

Simplicity in Endodontics—Mr. D. London.

Does the Baldwin Technique Inhibit Marginal Seepage?—Mrs. C. S. Osborne.

Modern Concepts in Cavity Preparation—Mr. J. E. Cardwell.

Gum Shields for the Athletic Patient—Mr. J. D. Haworth, Mr. P. Ayling.

Guy's School for Dental Surgery Assistants—Mr. M. L. Maberley, Miss S. Bennett, Miss E. Druce.

Intravenous Diazepam in Conservative Dentistry—Mr. R. L. Wood, Mr. I. A. Nelson.

Hydrocolloid Impression Technique—Mr. D. Thompson.

Comparison of new amalgams—Mr. M. Schaller, Mr. A. A. Macdonald.

DENTAL MATERIALS SCIENCE

Films—

The Production of a Porcelain Jacket Crown. The Casting of a Porcelain Cast Gold Crown—Dr. D. Brown.

DEPARTMENT OF PROSTHETIC DENTISTRY

Impression Technique for Fibrous Ridges (Tape slide programme)—Dr. J. D. Walter.

Overdentures—Mr. W. A. V. Beare.

Demonstration of the uses of the Mandibular Kinesiograph—Professor D. J. Neill, Mr. H. W. Preiskel.

Stages in the construction of the Immediate Replacement—Teaching Technicians.

DEPARTMENT OF PHYSIOLOGY

A study of forces in eruption—Mr. R. A. Burn-Murdoch.
Properties of intra-oral mechanoreceptors—Dr. R. W. A. Linden.

DEPARTMENT OF DENTAL RADIOLOGY

Interesting Radiographs—Dr. F. L. Ingram.
Quiz—Mr. B. W. Beeching.

DEPARTMENT OF ORAL AND MAXILLO-FACIAL SURGERY

Diagnostic Quiz (Cases seen in the Primary Treatment Unit)—Mr. R. A. J. Shaw, Mr. P. L. Titchin.
Fractures of the Middle Third of the Facial Skeleton—Mr. P. M. O'Driscoll, Mr. M. C. Mace, Mr. G. M. Carter, Miss R. E. Hickman, Mr. C. B. Muir.

DEMONSTRATIONS BY CONSULTANT DENTAL SURGEONS

Minor Oral Surgery under local anaesthesia and intravenous valium sedation (Floor 22, 11.00 a.m.)—Mr. R. C. Bret Day.
Technical considerations in tooth transplantation—Mr. D. H. Gibb.

DEPARTMENT OF PERIODONTOLOGY AND PREVENTIVE DENTISTRY

Selective Grinding in the Treatment of Periodontal Disease—Professor R. D. Emslie.
Topical Fluorides—Professor M. N. Naylor, Mr. P. J. Mainwaring.
Treatment Planning—Dr. F. P. Ashley, Mr. D. N. Gouk.
Your Treatment Plan Please—Mr. P. J. Kerr, Mrs. B. A. Hudson, Mr. C. Wynne-Davies, Mr. C. R. Debenham
Tooth Mobility—Mr. C. A. Waterman.
The Phase Contrast Microscope—Dr. F. P. Ashley, Mr. R. F. Wilson.
Plaque Control—Mr. D. W. Macfarlane and the Hygiene School.
The Bone Blend Technique in Periodontal Surgery—Surg. Cdr. E. J. Grant.

DEPARTMENT OF ORAL MEDICINE AND PATHOLOGY

Experimental dental caries from breakfast cereals and its prevention by a glycerophosphate additive—Dr. T. H. Grenby.
Scan and transmission electron microscopy:
Ultrastructure of salivary glands—Dr. Doreen Pugh.
Ultrastructure of oral mucosa—Mr. K. C. Rajasingham.
Candidiasis—Mr. K. C. Rajasingham.

DEPARTMENT OF ORAL IMMUNOLOGY AND MICROBIOLOGY

Histocompatability antigens in recurrent oral ulceration; Phagocytosis in oral disease; The effect of immunopotentiating drug, Levamisole, on gingival inflammation —Professor T. Lehner, Dr. J. M. A. Wilton, Dr. S. J. Challacombe, Dr. L. Ivanyi, Dr. M. W. Russell, Dr. C. Scully, Mr. J. Lamb.

DEPARTMENT OF ORTHODONTICS AND DENTISTRY FOR CHILDREN

Endodontic treatment of a tooth with an open apex—The staff of the Paedodontic Section.
Treated Cases—The staff of the Orthodontic Section.
Useful Tips—The staff of the Laboratory.
Cases treated by Students
Treatment of Unerupted Teeth—Mr. A. C. Campbell.
The Sublime and the Ridiculous—Professor W. J. Tulley.

STUDENT CLINICIAN PROGRAMME

Dentsply, in conjunction with the British Dental Association, have invited each Dental School in the United Kingdom to nominate one student to present a table demonstration at the B.D.A. Annual Conference to be held in Birmingham in April.
The two demonstrations by students judged to be the best at the Conference will be invited to attend the American Dental Association meeting in California in October, at the expense of the organisers.
The Demonstrations by Guy's students which are to be judged for nomination to the B.D.A. Conference by Professor Emslie, Dr. Binnie and Mr. Bret Day will be in the Library/Museum on Floor 27.

Guy's Hospital Dental Society

Annual Dinner & Ball

Saturday, March 4th, 1978

at

The Grosvenor House Hotel

Single Tickets at £10.00

from Colin Mitchell
Gillian Smith
Geoffrey Pigot
c/o East Wing or Floor 24, Guy's Tower
or through the
Dental Year Representatives

CLOSING DATE FOR APPLICATIONS – 10th FEBRUARY, 1978

QUODLIBET SOCIETY

Any Questions?

December 9th, 1977

It was two years after its re-inauguration that Quodlibet lent itself, for the first time, to the National Ears. The great success of this occasion suggests the possibility of further extravaganzas of this sort in the future.

Before David Jacobs and his panel took the floor, Geoffrey Owen controller of Radio 2, explained something of how the business of radio is done, and was heckled, unfairly perhaps, for his management of what is after all a self-confessedly light entertainment programme. After this, the twelve questions good and true, were selected and the majority of us suffered the indignity of finding that our questions were not the most fascinating that had ever been presented to a radio producer. The ones chosen were all serious and of more or less national interest. Those like myself, who thought that they had handed in excruciatingly witty questions were put in their place by the producer, who complained that there was an absence of light hearted questions.

At last David Jacobs with Lord Robens, Malcolm Muggeridge, Harold Evans and Sue Slipman entered the theatre. Suave and in control of the situation David Jacobs demonstrated the sound of running water close to a microphone and told a rather risqué joke about an Indian doctor, (he always tells that one they say) but then they always do say that. At last with the calm voice of an airline pilot he abruptly jettisoned the proceedings in the Tower into homes all over Britain; the "red" light was on.

The discussion roamed smoothly from the National Front (who sent us a letter offering to reply), to dying with dignity, to Sadat's peace initiative. All the panellists were very much themselves and even Sue Slipman whose brief was to counterbalance the more "established" views of the other speakers, proved predictable in her answers. But then predictability is the essence of Any Questions success, it aims generally to bring a sane set of perspectives into a confusing world. Its speakers, as on this occasion, play to the studio audience who register their approval as representatives of the man on the street—the listeners at home.

The eloquence of the speakers was remarkable especially when it is considered that they have so little warning, Harold Evans ascribes this fluency to the fact that most of the people on such a panel, unlike the rest of us, have had to make up their minds on such questions already. Yet there is more to account for such speed of thought under stress, as he himself demonstrated, when he produced an admirable skit on the rape of the English language, ad lib. Bungles can always occur and we had a magnificent example of how a team can cover them up. The last question was meant to have been one on the grants system but due to a mix up in the numbers the actual question asked was about Sadat's peace initiative, nevertheless with typed questions on the grants system in front of them, the team proceeded to a solution of the middle east situation, seemingly oblivious to the producer suffering from apoplexy behind them.

The mood throughout the evening was notably one of cohesion and intimacy between an audience drawn from many different aspects of Guy's and between the speakers themselves; from Malcolm Muggeridge calling Lord Robens, "Alf", every time he wanted to stress his own spiritual point of view, to David Jacobs continually adjusting the distance between Sue

Slipman and her microphone. Helped by the acoustics of the theatre, the audience was very responsive, indeed to some of the listeners, apparently, they appeared positively manic.

Finally though, the red light started flickering and it was time for those very quick replies that leave everyone sitting on the edges of their seats wondering how long the speaker will go on for. In the end our faithful red light disgraced itself by refusing to extinguish. So Mr. Jacobs deftly gave it the kiss of death by pouring his jug of water over it, thus the programme ended.

It would be impossible to conclude an impression of that evening without praising the technical genius of Mr. Rytina, his staff and the organising conscientiousness of Mr. Bompas, who added an unseen touch of the impressario to the proceedings.

This term's programme for Quodlibet consists of three speakers from the Arts' world and a debate. We will be returning to the political arena next term when John Pardoe and Arthur Scargill will be among our speakers, and to the world of cognitive thought with the lateral thinker Edward de Bono. Some details of this term's meetings include:

Thursday, February 9th (date provisional)

"The Law has no place in solving problems of Racial Discriminaion." —Debate with a barrister and a journalist as guest speakers. We need two further main line speakers from Guy's; could any student or member of staff who would like to speak please contact me or the Hon. Secretary?

Tuesday, February 28th

Andrew Cruickshank, well known as Dr. Cameron in Dr. Finlay's Casebook, will speak on the Medical Profession as seen by a man who has "acted" within it for so many years.

Thursday, March 9th

"Art and Pornography" by Peter Webb.

If you missed this at the L.M.G. conference on Human sexuality, this is your chance to catch up. Using two projectors, Peter Webb presents a wealth of fascinating, illuminating yet totally inoffensive material.

Anyone who would like further details, or who would particularly like to eat with any of the speakers, should contact myself or Richard Trembath through the Quodlibet in-tray. The same goes for any suggestions or requests for future meetings. They are all on the 30th floor tower at 5.30 p.m. with free tea and biscuits provided. Everyone in the hospital is welcome—the society can only continue with your support.

Michael Dixon.

Reviews

HOSPITALS' CHRISTMAS CAROL CONCERT

Royal Albert Hall

21st December, 1977

To celebrate ten years of the Hospitals' Christmas carol concerts in aid of the Malcolm Sargent Cancer Fund for Children, the event was held in the Royal Albert Hall instead of its usual venue, the Royal Festival Hall. Twenty-one of the choir of 800 were from Guy's, the usual 30 girls' places were

restricted to ten, an unfortunately small representation. Seven thousand people packed the hall in the presence of H.R.H. the Prince of Wales and the Archbishop of Canterbury to hear many carols arranged by Malcolm Sargent sung by members of the London teaching hospitals and representatives from hospitals as far afield as Wigan and Manchester.

The concert, which was conducted as in previous years by Charles Farncombe, began with an impressive fanfare by the combined trumpeters of the Royal Corps of Signals and the Royal Artillery. The carols that followed were a pleasing mixture of traditional melodies with enthusiastic audience participation and music from many parts of the world specifically arranged for choir.

The choir, the ladies of which were dressed in the nurses' uniform of their own hospital, were very well drilled—some achievement considering the short rehearsal time available and long distances travelled by many members, and gave particularly fine performances of the Mexican carol "Earth's Joy" and two negro spirituals in the first half. After the interval they sang several further arrangements including the "Nightingale Carol", "Silent Night" and "Hawaiian Lullaby" by lantern light, a delightful effect adding to the seasonal nature of the performance.

During the concert light interludes were provided by the Alan Civil Horn Quartet who played a variety of arrangements of secular Christmas music which were both technically brilliant and highly amusing. The organist, John Birch, also contributed to the success of the evening with a rousing performance of the toccata from Widor's fifth symphony, always a great favourite.

The concert was concluded somewhat unusually with "Ring Out, Wild Bells" from Tennyson's "In Memoriam" followed more traditionally by "We Wish You A Merry Christmas" with two encores, a fitting end to a thoroughly enjoyable performance which raised over £10,000 for the Charity.

Alasdair Jacks.

GUY'S HOSPITAL MUSIC CLUB CHRISTMAS CONCERT

On Wednesday, 7th December, the Music Club gave its annual Christmas concert in Southwark Cathedral; performing parts I, V and VI of Bach's Christmas Oratorio before an excellent turnout of over 250 people, despite the abysmal weather conditions on the night. The Club and its conductor, Peter Soothill, did credit to this most pleasing of works although as usual with recent Guy's choirs the female : male ratio was high enough to place rather a burden on those few men who did perform.

The concert began with rather studious expressions on the choristers' faces as they sang the opening "Christians, Be Joyful", although it sounded marvellous; this was followed by excellent solo passages from Norman Lloyd-Miller (tenor) and Julia Field (contralto). The central chorus in part I, reminiscent of the earlier St. Matthew Passion, was performed with feeling although the choir appeared so well drilled as to be without need of the conductor in some passages.

The orchestra, mostly from Guy's (the trumpeters, one oboe, the organist and timps were imported) was consistently sympathetic and well balanced

throughout the performance erring only on the loud side in some solo passages in each part. It was unfortunate that the acoustics caused the timpani to sound intrusively loud in many passages.

In part V some of the momentum was lost, especially in the difficult opening passages, although once again the soloists were excellent, only the bass being rather overshadowed by the orchestra's zeal.

In part VI both choir, soloists and orchestra excelled themselves with fine performances of the first two choruses, and a really triumphant rendering of "Now vengeance hath been taken on all the foes of man, and Christ doth end in triumph the conflict he began . . ." to conclude a thoroughly enjoyable concert.

Alasdair Jacks.

U. L. U. "H.M.S. PINAFORE"

Clad in an elegant pair of tatty jeans, neatly trimmed with intricately designed frayed ends, Adam Skinner dominated the recent production by U.L.U. of Gilbert and Sullivan's "H.M.S. Pinafore" or the "lass that loved a sailor". His exquisite voice and perfect diction gave the lie to his own complaint that his tongue is too big! Nightingales can be boring—but our Adam is not!

He was supported in his first public performance by some very competent and amusing performers; notably Peter Crockford, appropriately enough an articled clerk, as Sir Joseph Porter, K.C.B., Christine Eve, a teacher, as Josephine, Glenn Wilson, a professional singer, as Captain Corcoran, and Janet Wilson, a psychologist, as one of the better Buttercups. The chorus was lively and, despite a few ghastly, self-conscious moves, well directed. They were led by Pauline Arnold and Robin Piper, needless to say, a couple of our chaps and chapesses.

My only criticisms of the production would be that it was all a little too serious and a bit too well done to be really funny—unlike a few productions I have seen! They were also very much hampered by a tiny stage although a few lighting effects and a cunning little sun, arising from the azure backcloth, displayed a certain amount of imagination.

All in all, it was a very enjoyable evening and we wish them luck in their next effort which is to be the "Sorcerer" . . . as long as they wish us luck in our own Guy's production, "Ruddigore", planned for early in March,—plug, plug.

G.S.S.

FILMS

There are two outstanding films in the West End at the moment, both are about romantic incompatibility, but there the relationship between them ends.

"The Lacemaker" (Academy 2, Oxford Street) is a beautiful film about a couple, who are very romantic yet incompatible. "Annie Hall" (just about everywhere) is above all a very funny film about an analytic couple, who think that they are incompatible.

In its heroine, "The Lacemaker" catches that age-old image of the instinctive female gazing knowingly into the distance, with just the suggestion of a smile on her face. But no fool this one, because she knows what she wants, and it isn't very much. Just a job of sweeping up in a posh Parisian hairdressing salon and a sympathetic, if excruciatingly serious, Parisian student. He, for his part, doesn't really know what he wants. He is, however, captured by the "image of the lacemaker", that she exudes and they embark upon an amusing and stumbling courtship, which will be appreciated by anyone who has ever felt a little silly when out a-courting. And so to bed, but not before conforming to the preliminaries of a champagne bean-feast, which neither enjoy, but which he feels they ought to have.

When they return from the typical seaside town where they met, to live together in Paris, reality begins and their problems begin too. Her simple innocence and passive silence stand in contrast to the eloquence and liberation of his questioning friends. To continue would be to spoil the plot. Except to say that there are some very colourful supporting characters. Like the heroine's boss and friend, who is a beautiful and middle-aged parisienne, *par excellence,* who talks only of clothes and men, and then complains that men are only out to sleep with her. The student's best friends are a young couple of "political agitators", but, who in contrast to everyone else, live in domestic bliss, and who are about to have a baby, when everyone is falling about around them. Like most French films (sub-titles provided), it is sensitive and sensual to the end.

"Annie Hall" is not sensitive in the same way, but Diane Keaton, who plays and really is in real life "Annie Hall", is sensual in every way. It is an autobiography "in cellulose" of Woody Allen and his relationship with Miss Keaton, and is by far his best film to date. Ever un-forgetting that he is a New York Jew, and five foot nothing at that, he plays his usual role of the neurotic, but friendly little bloke, who would like to be a Robert Redford in sexual overdrive. Not surprisingly, his complexes and perpetual self-analysis turn Diane Keaton frigid (both on film and off), though it has to be admitted that as far as sheer neuroticism is concerned, there isn't much to choose between them. The complete honesty of the film is sometimes almost embarrassing, as if he were asking the audience to answer the question that he constantly puts to himself, "Where the hell did I go wrong?"

There are some memorable scenes in the film, such as the one in the cinema queue, when a bore standing behind Woody Allen is rabbiting on about some author. Woody Allen, disagreeing with both the style and the content of the bore's loud delivery, fantasises the appearance of the author on the scene to tell the bore that he is talking absolute rubbish. There is another scene too, when Woody Allen and Diane Keaton both go to see their respective analysts to try and get the relationship sorted out. On being asked how often he sleeps with Diane Keaton, he replies "only twice a week". When she is asked the same question by her analyst she replies "a lot, at least twice a week". Unforgettable is the line after they have made love when Woody Allen congratulates her on her performance, "that was the next best thing to laughing".

The film is clever and funny, and it should be part of every metropolitan gentleman's or gentlewoman's viewing. Not because we are all five foot nothing New York Jews, but because by its sincerity it has a message for all of us.

Now to two more traditional films of a different ilk. "A Bridge Too Far" (Gala Royal, Marble Arch), now being rather unfairly called "an hour too long" is the ultimate in a good war film, without any of the irrelevancies of a super-added romance. The plethora of well known stars is confusing, they really aren't required in such numbers for a good war film, and you keep feeling you ought to clap whenever yet another famous actor hits the screen. Nevertheless the British actors, Dirk Bogarde in particular, are predictably the best. Incidentally, those who were there at the time claim that the plan was not in fact a stupid fantasy of senile generals, and that, but for the incidental hitches, it nearly did radically alter the course of the war. (Europe's boundaries today would be very different had it succeeded.)

If you like oogling at Catherine Deneuve or simply like Foreign Legion films, "March or Die" (ABC, Shaftesbury Avenue) is quite an entertaining film. The battles, the gallantry and the chivalry are all predictable and well done. The plot isn't. At first you might think that Catherine Deneuve had been seduced by the tough chauvinist, Gene Hackman, because it is the fashion in such films for the heroine to hate the toughie before submitting herself to his engulfing masculinity. But you would be wrong. She sleeps with Hackman, who is the general, and various anonymous ticket collectors on the way as a means of toughening up her real lover, who is a far too nice American raw recruit to the legion. You might expect too that at the end of it all, the two lovers would wander away into the desert together arm in arm. Far from it. At the end of it all, the recruit, who has meanwhile become a general too, decides that staying in the legion is far more fun, and presumably safer than running off with Catherine Deneuve. Undeterred, and in the anti-climax to beat all anti-climaxes, Catherine Deneuve, now desperate, looks around for an alternative lover and digs her claws into a rather weedy and inoffensive archeologist, whom she returns to England with.

Finally, if you are feeling too weak for war films, too tired of analytic ones or too confused for romantic ones, you could always go and see "Star Wars" (everywhere shortly) or "The Spy who loved me" (Pavilion, Piccadilly Circus) both of which are rubbish certainly, but which stand out as excellent rubbish.

Michael Dixon.

WHAT IS WRONG WITH THE NHS?

by Dr. David Armstrong, M.Sc., M.B., B.S.
of the Unit of Sociology as applied to Medicine

The crisis in the NHS is not a crisis of organisation (Have we too many administrators? Or a management tier too many?) nor is it a crisis of finance (Will a London teaching hospital have to be closed? Should obstetrics receive less money?). It is a crisis of knowledge and social values. The fundamental question is not "What is wrong with the NHS?" but "What is health?".

Challenging the old consensus

The NHS was introduced in 1948 with the Minister of Health charged with the promotion of a "comprehensive health service . . . and for that purpose to promise to provide or secure the effective provision of services". There was no definition or discussion about what health actually was but

the confidence with which its attainment was viewed is revealed in the then current belief that the cost of the new health service would gradually decrease as disease was mopped up and the nation became healthier.

In 1948 the realisation of health and the identification of health needs fell mainly to the doctor. It was the medical profession through its specialised skills in diagnosing and treating disease which played the central role in the maintenance of good health. Within the last few years however that role has been challenged from various quarters.

Firstly the growth and complexity of modern medicine has necessitated a considerable expansion in the numbers and types of occupation employed in the NHS. Many of these occupations—especially the "para-medical groups"—have become increasingly vocal in their claims to a larger share of control over what they do in the health service. Groups as diverse as physiotherapists and laboratory technicians, administrators and clinical psychologists are challenging the old consensus which gave doctors almost sole rights to define patients' health needs.

Secondly the technological promises that medicine held out thirty years ago have not materialised in the way imagined. In the recent monograph of his Rock Carling Lecture, McKeown claims to show that most of the increase in life expectancy over the last century or so was due to social and economic change rather than to specific chemotherapy. This disillusionment with the technological capability of medicine has been furthered (in some cases perhaps too far) by various studies which have cast doubt on the effectiveness of many traditional and well-accepted treatment regimens.

Thirdly, though the public may not be fully versed in the academic debate on the technical effectiveness of medicine they are aware that the treatments of most of their minor ailments and chronic disabilities has hardly changed over the last thirty years. For many the quality of services has declined due to the increasing size—with its concomitant bureaucratisation—and over-reliance on technology of the health service. If sickness absence statistics are an indication of how the population rates its own health then their consistent rise throughout the NHS suggests a failure of the service to meet patient-defined need.

And fourthly the government has become increasingly concerned at the apparently insatiable appetite of the NHS for funds. Just over a decade ago it was realised that as no objective measure of health existed it was open for doctors and for patients to claim to identify some new health need which required more money. The potential demand for health care seems enormous and no government can hope to meet it all. The result is attempts by government to ration health resources, but the criteria adopted to identify priorities are frequently at variance with health needs as defined by the medical profession.

Problems in focus

The NHS started with a confidence (if falsely based) in a common purpose. The picture now is of various groups—doctors, health workers, administrators, government and patients—all claiming an interest in how health is defined. Many of the problems currently encountered in the health service can be seen as the consequences of this dilemma.

Without a consensus about what the NHS should be doing it is almost

inevitable that there should be debate as to an appropriate administrative structure. An organisational structure for a manufacturing plant can be based on the most efficient means of achieving the final product and various schemes can be compared by measuring output. This is not possible in the NHS.

Consider, for example, a hospital. Should it be saving lives? Getting people home more quickly? Increasing patient satisfaction? Advancing research? As well as possibly being in conflict, the achievement of each of these goals may merit a different organisation. The surgical ward may be run as a military exercise if "through-put" is the goal or like a holiday camp if it is patient happiness.

In essence therefore much of the argument about an appropriate management structure for the NHS is a debate involving the promotion or reconciliation of conflicting aspects of health. With no consensus on what health is there can be no agreement on administrative structures.

The problems arising over the financing of the NHS in part reflect the general economic climate but this has probably been more of a trigger to an already difficult situation. The NHS is meant to direct resources to where they are most needed: but if there is no agreement on what constitutes health need and health priorities where should they go? The government decides they are needed more in general practice so demand for hospital care can be reduced, the hospitals claim they are needed to replace out-dated facilities and sagging morale. The Resource Allocation Working Party established by the DHSS tries the impossible task of defining health need; by using mortality figures as proxy—indicators of need they argue resources should be moved from London to the provinces. London inevitably disagree that mortality adequately represents need. And so on.

In Conclusion

The W.H.O. defines health as a state of complete physical, mental and social well-being. This state is probably unattainable for the vast majority of the population but this will not prevent them from trying. Yet while there may remain some consensus on what constitutes physical well-being (ignoring for the moment the influence of psychological and cultural factors on it) this is not the case for mental and social well-being. These represent social values which have a closer link with politics than with the biological base of much of modern medicine. In as much there can be no agreement on social and political issues—such differences are a part of our pluralistic society—then there can be no agreement on health. Without this agreement the NHS will be permanently in conflict.

This does not mean the health service is doomed; other institutions such as science have actually thrived on conflicts and internal disputes. The change that is required in the NHS is to accept conflict as normal. The time has passed when health could be regarded as a biological absolute constituted in the absence of disease. There is nothing fundamentally wrong with the NHS; it has simply changed. Health, as a part of politics, must become the art of the possible.

NURSING

Nurses as Negotiators

During recent years, and in particular since the reorganisation of the Health Service, the role of senior nurses has been changing with great speed. It has been necessary for them to develop their managerial skills to a much greater degree in order that they may be competent to work as members of multidisciplinary teams.

Although attendance at committee meetings has always been a part of their work, it has gained increasing importance, and for the profession to obtain its objectives the ability to state cases clearly and with authority is now an essential requirement.

Nurses do not usually make very good negotiators. Like doctors, their basic training teaches them that the needs of sick people are paramount and should be met regardless of any factors such as cost. As a result of this, they assume that everyone else will think likewise, and that no negotiations to establish priorities will be required. The average ward sister is a person of very high ideals and a somewhat narrow outlook, indeed, she would be considered inefficient were this not the case. She is usually deeply concerned only for the welfare of the twenty or thirty patients in her care, and is oblivious to any demands which have to be met outside her immediate environment.

As the nurse gains promotion she has, sometimes rather painfully, to learn that there are much wider issues which have to be considered and should learn to develop the skills which will enable her to present her viewpoint. This education frequently comes late in a career, with the danger that the skills will not be acquired at all.

To state one's case lucidly and confidently at a large meeting requires courage as well as skill. All too often nurses lack these and remain silent, or, worse still, agree to all proposals, they then complain afterwards that the agreements are impractical. Not surprisingly this proves to be a source of annoyance and does not improve the image of nurses as a profession or as competent managers.

It is surely time that some thought be given to these facts at a much earlier time in a nurse's career. Her basic training should be broader in concept with a view to producing a person with wider horizons than is frequently now the case, she would then be able to accept her role as a manager more readily.

The medical profession could of course assist in this by educating their own members to these needs. Each specialist jealously guards his own territory and seeks to work autonomously and in many hospitals this is now causing much discontent; tales of difficult medical staff are commonplace and the pressures exerted on nursing staff are extreme.

The traditional strength of the doctors and the submissive attitudes of nurses are still very evident and until the latter learn to exert their influence more effectively as an independent profession the situation will not change.

Nurses need to widen their horizons considerably and this should be inculcated at an early stage, otherwise the profession will continue to experience difficulty in achieving its objectives and the care of patients will suffer.

Pam Jefferies

PHYSIOTHERAPY

Degree Courses for Physiotherapists

For many years past, we have offered a training for physiotherapists which has been internationally recognised as good or even excellent, and it might not be too extravagant for us to claim to be the Mother of Physiotherapists, standing in the same relationship to the world that Westminster does for parliaments.

However, in recent times we are being made to accept that our certificated physiotherapists working abroad are becoming regarded as substandard by comparison with the locally-trained graduates, to the extent that they are sometimes paid on a lower salary scale, and that they are required to provide evidence of some sort of academic respectability before they can become registered to practise in that country.

In some countries which had hitherto welcomed with gratitude British-trained staff, physiotherapy is becoming an all-graduate profession, while here we have only one degree course, in Northern Ireland, and that is only in its second year and was very nearly restricted to a single intake by a Privy Council decision which was later reversed.

The Chartered Society has assured the Health Ministries that it is not pressing for an all graduate profession and that it envisages only a minority of physiotherapists taking a degree, but in view of the development of University and C.N.A.A. courses in other paramedical disciplines and in occupations outside medicine, it is difficult to see why such resistance is forthcoming.

We know, of course, that ours is a practical profession and will ensure that competence to practise is the base-line for state registration, but it has a considerable theoretical or academic foundation and entrants to training are now—certainly at Guy's—people fully capable of and qualified for graduate courses.

One can only suppose that the salary-structure implications are frightening off the Health Ministers—although other non-medical degree-holders working for the D.H.S.S. might not think that their salaries would justify such a fear. Alternatively, there may be a feeling among the D.H.S.S. advisers that physiotherapists are presently quite adequately educated for the work they have to do, and that it would be superfluous to raise the academic level of the course any further.

Whatever the reasoning may be, it is an unusual situation for us to be in by comparison with other nations, and one which we find hard to take. We must hope that the several schemes now in preparation for end-on degree courses for qualified physiotherapists and for full-scale degree courses at polytechnics will achieve success when they are presented. Perhaps, ministerial reconsideration will allow for developments along these lines to be acceptable in the future, but perhaps you, our colleagues, would not support our aspirations? We would be interested to have your opinion.

Ronald Cooper.

RADIOGRAPHY

Students' Practical Technique Assessment

In April 1978 the College of Radiographers qualifying examination for diagnostic radiographers will undergo a change; the technique examination is being drastically altered. The syllabus remains the same but instead of the previous three hour written examination of six essay questions the new examination consists of some thirteen questions, still extending over three hours, but divided into sections with marks for each section increasing from five to twenty depending on the amount of detail required. The theory behind this new examination is to cover more of the syllabus with shorter more concise questions, thus examining candidates' more general knowledge and not just limited to six topics. To most radiographers this seems like a change for the better, however I'm not so sure that the students taking this examination for the first time in April will immediately agree!

It was decided that technique assessment was a relatively simple matter to undertake in those departments where each student was stationed for any length of time; at the end of these periods the superintendent or senior radiographer principally involved in the teaching and supervision of the students complete the assessment form. However the problem is not so easily solved in the main Tower X-ray department where a student may only work with a particular radiographer for a matter of days. How therefore to assess standards over a period of time with numerous staff?

For students working in the main Tower X-ray Department a full technique assessment would be submitted to the School by Miss Hampson, Superintendent in charge of Tower X-ray, once a term. Due, however, to the large numbers of students this would be a very difficult task to perform alone, so she will be helped by regular reports given to her by her senior radiographers. In discussion is was decided that it was very difficult to recall at any instant a particular student's technique standard. Not only will she comment on the student's technique but anything else about the student that she thinks warrants attention or merit; the staff are advised to give full comments wherever possible as opposed to single word remarks, with some suggestions for helping the student. It is hoped that with these regular reports no particular incident will bias the student's assessment report and a more accurate overall picture will be obtained.

There will also be weekly practical technique checks held, usually, on Friday afternoons by the senior radiographers on a rota basis.

Using these weekly assessments by the senior radiographers the superintendent in charge will be more able to give a fairer and more accurate term assessment on the students' technique ability and progress. These reports will then be submitted to the School of Radiography where they will be shown and discussed with the student by staff of the School. The student is asked to comment and disagree with the report wherever she thinks the report warrants it; students will be asked to sign the reports if they accept the contents as fair.

It is hoped that this new system will help in the students' technique tuition and that any faults will be discovered earlier, allowing for quicker correction. Of course it also opens up many more interestnig and lucrative sidelines for any enterprising senior radiographer and any desperate radiography students!

Jill Guest.

BOOK REVIEWS

"A Primer of Human Neuroanatomy", by Cynthia Reid. Pp. 194. Price £2.90. Published by Lloyd-Luke.

Most students have considerable difficulty in learning and understanding the structure of the central nervous system. Because of this a number of short textbooks on neuroanatomy have been written with the purpose of reducing the amount of information found in the larger textbooks. More important is the author's intention to simplify the subject so that the student can understand neuroanatomy more readily. The book being reviewed comes into this category and in terms of the amount of information it should be more than adequate for the purposes of the preclinical student. There is some doubt as to whether the information is presented clearly enough to make it easily understood. This is mainly due to the number and type of diagrams used. Frequently the diagram is oversimplified and sometimes misleading e.g. the figure of a nerve cell on p. 2 shows nodes of Ranvier (unlabelled) inaccurately, the figure of the tracts associated with touch suggests that the neuron forms two ascending tracts, and the nucleus ambiguus of figure 57 could not possibly correspond with the nucleus of the same name in figure 59. It is appreciated that drawings, diagrams and pictures can make a book prohibitively expensive so that simple line drawings are used, but they can be accurate and helpful.

Some individual chapters can be strongly recommended. The hypothalamus, extrapyramidal system and reticular formation are very well described, as well as the relationship between the olfactory pathways and the limbic system.

There are some infelicities of language such as "on the whole this nucleus is to do with agreeable sensations" (p. 105) and the use of the plural for bilateral structures (pp. 152 and 164). If interthalamic adhesion is used (correct Nomina Anatomica, although I have not seen the latest, very recent edition) can corpus mamillare be used instead of corpus mammillare and locus ceruleus and not locus cerulus?

This book can be recommended to students who want a short, adequate description of the human central nervous system at a reasonable price.

J. JOSEPH.

"Handbook for Dental Surgery Assistants and Other Ancillary Workers", 2nd edition by Stanley Gelbier and Margaret A. H. Copley. Pp. 243. Price £4.50. Published by John Wright, Bristol.

Each year about two thousand girls sit for the National Certificate set by the Examining Board for Dental Surgery Assistants. Only a few will be lucky enough to prepare for this by taking a full-time training course. Most of them will rely upon one evening class per week in further education centres plus whatever they can pick up over twenty one months in general practice. For this majority, one suitable textbook for essential basic information therefore becomes almost a gospel since they are naturally unable to sift out the detail relevant to their needs from the plethora of dental literature. Fortunately the Board publishes a syllabus so the choice of book, in theory at least, is easily reduced to a choice of one from about three on the market written with this certificate partly in mind.

This handbook claims to provide "sufficient background knowledge for all varieties of dental ancillary workers, including dental surgery assistants, auxiliaries, health educators, hygienists and technicians". If such an immodest claim were fulfilled, it would only remain to say that this book is the obvious one to recommend. Alas the aim falls wide of its mark in too many places.

The first edition published in 1972 at £2.75 was five millimetres greater in length and breadth but had fifteen pages less. Improvements in the second edition are a consolidated glossary and the inclusion of information about some of the more recent dental materials, for example composite and glass ionomer cement. Little else of the text has been altered but a rearrangement of the chapters was logical and by amending the introduction from a preamble to become Chapter I. "The Dental Scene", an extra chapter appears added to the page of Contents, in spirit if not in the body of the book.

Considering there are so many excellent line drawings in modern publications, it is particularly sad that the opportunity was missed in this second edition of replacing some of the more graffito-like diagrams. Even allowing for extreme simplicity to make them easily reproduced under exam conditions, there is no excuse for inaccuracy. Sloppy drawing may on occasion cast suspicion on a careless text as was indeed borne out by study of many descriptive details, which come in a mixture of note and essay form.

The digastric muscle (fig. 18) appears unusually aberrant and it is difficult to imagine where it could be attached to the maxilla as we are told on page 40. The position of the foliate papillae (fig. 17) is ambiguous from the sketch and the text hardly helps by failing to mention them. On the other hand, the more abundant filiform papillae are not named in the drawing. Probably the most scrawling example (fig. 14) is only identifiable because the type set caption reads. "Anatomy of temporo-mandibular joint". The neck of the condyle according to the label appears to sit centrally in the head of that projection.

Broadly speaking, the sections on anatomy and physiology, both general and special, need many corrections. For instance, the heart is described with "its broader base . . . to the right and above the collar bone". Later (page 19) "the walls of the auricles are smooth with a number of muscular projections (papillary muscles) which form fine tendons (chordae tendinae) at their free ends". On the next page we learn that "heart valves consist of tough cartilage".

Although the printer's devil may well be responsible for setting up the statement, "Platelets . . . take part in the blood-cutting process", he could hardly be blamed for the description of the circulation through the lungs (page 21) with red blood cells in capillaries around the air sacs "giving off their oxygen and taking up the carbon dioxide". Most examiners would only accept the opposite of this sequence for a pass mark.

It would be churlish to go on listing all the errors because there are so many, but one misconception especially should not go unchallenged. The result of carrying out the following advice (page 190) is contrary to the patient's best interests: "If necessary, cardiac massage and mouth-to-mouth breathing must be continued by the same person, doing first one for 20 second and then the other". Whereas, it would be far safer and more likely to succeed in maintaining life under such emergency conditions to reduce breaths to about eight spread throughout each minute, interrupting cardiac massage only minimally.

Coming to the meaty dental part of the book, there were certain areas which were underdone when compared with the portions on anatomy and physiology which seemed overdone. Bridges are dismissed in five lines as "artificial teeth embedded in an acrylic base". One of the most important reasons for rubber dam in endodontics, protection of the pharynx, is not given a mention. Tungsten carbide is not a metal, which may sound like carping but if that degree of definition is attempted it must surely be accurate. Similarly, alternating between the term zinc oxyphosphate and zinc phosphate cement without explaining the inconsistency must be confusing to the uninitiated. A warning about the hazards of UV light should have been included in the description of its application. However, to be kind, there is much in the dental section which is easily digestible and the questions from previous examination papers at the end of each chapter are carefully chosen.

While I may not recommend this edition as a reliable authority to "those for whom it was written" I look forward hopefully to the next, a third edition, after suitable replacement of the less useful diagrams and correction of the text. With such a meagre number of books aimed at the growing army of ancillary dental workers in the U.K. those already in print enjoy a preferential position which will fall as more are published and competition increases.

MICHAEL MABERLEY.

"Orthodontic Treatment with Removable Appliances", by W. J. B. Houston and K. G. Isaacson. Pp. 144. Price £5.00. Published by John Wright, Bristol.

This handbook is extremely readable and does provide a practical manual for the dental practitioner. It is really an enlarged version of the sections which appear in larger text books.

The authors rightly claim that there is no universal application for removable appliances, but that a large proportion of malocclusions seen in dental practice can be treated to a high standard with the types of appliances they describe. They also indicate that meticulous attention needs to be paid to appliance design and case management.

The authors wisely limit description to a series of simple appliances, giving precise details of construction and the way they should be handled. The handbook is well illustrated and full of many helpful tips on case management. The line diagrams are particularly good.

This book should really be part of the library of any practitioner who is treating patients with removable appliances and will help in liaison with the dental technician. The appendix dealing with mechanical properties of removable appliance components provides a very useful scientific basis, which stems from work done by the Materials Science Department at the Royal Dental Hospital, and they are to be congratulated on this very helpful chapter. The chapter on suppliers of materials and equipment is also of very great practical significance.

W. J. TULLEY.

CORRESPONDENCE

Opening Times at H.O.P.

Madam,

I would like to use the columns of the Gazette to make public a grievance which has been simmering for some time.

I refer to the non-opening of the bar at H.O.P. at licensed times, and its invariable closure before the authorised, accepted, closing time on the occasions when it is open.

From what I gather (and I admit that there may be some discrepancies in the exact times), the bar at H.O.P. is licensed, and presumably supposed to open for members' use for roughly three hours at lunchtimes and roughly five hours in the evenings. For it not to open at all during evenings in summer when members are playing tennis and cricket, and for it to close at seven o'clock or earlier on Saturdays when rugby teams are entertaining guests is, to me, unjustifiable and unforgivable.

Irrelevant or unrealistic platitudes have, in the past, been put forward in response to comments concerning the bars in the students' club and at H.O.P., so if I may put forward what should be rhetorical questions to the most usually quoted sayings, perhaps these platitudes can be replaced by informative replies.

Many excuses have tried to explain the inconvenience to which members are put, and I quote—"the groundsman needs some time off, you know" (was he not told the conditions of the job when he applied for it?); "they've arranged to go out tonight" (ditto?); "if you want any more, you can come and knock on the front door for it" (huh??); "there aren't enough people left to stay open—they're allowed to close if there are less than "x" customers left". (Really? Who decides what "x" shall be, and if this story is true, then does anyone care what damage comments such as "you don't want any more do you?—Good," can do to the hospital's reputation?)

Basically, madam, my comments can be summarised thus—are the facilities at H.O.P. meant for the convenience of the members, or are they to be available solely at the discretion of the groundsman and his staff? If the latter, then I feel that the administration of such matters is in need of an immediate, radical overhaul!

Yours faithfully,
R. J. ROBINSON.

60 Doverfield Road,
Brixton Hill, London, S.W.2.

Candidates for Medicine?

Madam,

I was interested to read the notes about the selection of candidates for places at Medical Schools in the Gazette of 26th November, 1977.

It appears to me that an academic level is a primary necessity below which a candidate must not fall. This means that a candidate must have passed what used to be called the "First Examination for Medical Degrees" in chemistry, physics and biology. A pass is all that is required of him. How many marks he got is not relevant. It is ridiculous to assume that because A got more marks than B in an examination which *both passed*, that A must make a better doctor than B. Consider the case of a hospital advertising a vacancy for a surgeon. The academic requirement is a University Mastership and the Fellowship of the Royal College of Surgeons. But no selection committee would dream of asking how many marks each candidate got in his examinations. Selection begins *after* the academic level has been reached and should include a review of the candidate's character and career so far and on the results of an interview and the interview is by far the most important. It is ludicrous to say that the members of an interview board cannot possibly see all the candidates. If they don't, they are not carrying out their duty. Every candidate for a commission in the services has to pass an interview board, and so should every candidate for a place at a Medical School.

It is almost unbelievable that some Hospitals have abandoned the interview because the interview boards have been *alleged* to discriminate in favour of "social class". It just shows how otherwise intelligent people have been brainwashed into believing that there is something disgraceful in a candidate being courteous and well spoken for I cannot think of any other possible distinguishing characteristic. In any case, is not this itself unfair discrimination against this candidate? Interview boards should remember their duty which is to select the candidates who are most likely to make good doctors, and if some candidates have natural advantages, then so much the better.

Yours faithfully,
S. J. WHEELER.

Hyde Beeches,
Hyde, Wareham, Dorset.

Many Thanks

Madam,

May we through you express our gratitude and thanks to all the members of the Hospital and School staff and other friends who, on the occasion of our retirement, contributed so generously towards our beautiful gifts.

They will always remind us of the happy times spent at Guy's and the friends we have made over the last 30 years.

Yours faithfully,

DORIS E. PUGH
ETHEL M. WESTBROOK

Madam,

As an old Guy's "running supremo", nearer the grave than the days of athleticism, one, indeed, did turn at the match report of the Hare and Hounds Club, that a team was completed by the inclusion of one of the opposite sex.

Remembering the difficulties of persuading sufficient like-minded lunatics to take on these trials, and in spite of being a self-confessed, male, chauvinist pig, one cannot but applaud the fine sporting effort of this lady.

Remembering, too, the often very inadequate changing and bathing facilities provided in this sport one feels considerable sympathy for the lady, who must have had her problems quite apart from completing the course.

Perhaps the presence of her and others of her sex is just what is needed to make "the loneliness of the long-distance runner" quite bearable and what an incentive!

Yours faithfully,

D.J.L.

A National Health Service?

Madam,

Many of the problems raised by Dr. Armstrong might be more easily solved if one called the National Health Service, the National Disease Treatment Service. It is easier to define (and treat) disease than health. It could be combined with a National Disease Prevention Service.

Yours faithfully,

J. W. OSBORN.

Unit of Anatomy in Relation
to Dentistry,
Guy's Hospital, S.E.1.

What is Wrong With the N.H.S.?

Madam,

Dr. Armstrong has posed his own question. What *is* wrong with the N.H.S.? I agree that it is important to re-define our objectives—but at the same time, let us pursue Dr. Armstrong's original question in terms of the practical nitty-gritty of how our existing Health Service is run. It *does* matter if there are too many administrators or a management tier too many. It *does* matter if health care delivery becomes a bureaucratic tangle instead of a personal service, if the need to set cost limits is misinterpreted as a need for more central control, if frustration among health care workers leads to strikes and industrial disputes and if, in this context, we come to accept that sick people may legitimately be used as a kind of strike fodder.

There is, of course, a great temptation to blame our failures on some kind of abstraction which cannot answer back. An example is the suggestion that a rise in sickness absence figures indicates "a failure of the service to meet patient-defined need". This definition begs the question. If, for example, a sharp rise in heavy colds on Cup Final day replaces a previously high incidence of grandmother's funerals, or if it becomes common to stay at home with a two-week illness over Christmas, does this suggest a failure in the Health Service? Let us not only criticise the doctor but also re-assess "patient-defined need" in this open-access society of ours.

There are other areas where this reappraisal is needed. Doctors would no longer claim a monopoly of wisdom in health care matters, but then neither should the lay public. There have been many recent instances in which, on totally inadequate grounds, Community Council views have reversed medical decisions on hospital development priorities or on what constitutes a viable hospital unit. Both for the hospital and the public at large, this kind of disregard of professional medical advice can, under our hierarchical structure, be taken to foolish or even dangerous extremes.

Another example of the search for scapegoats is the current tendency to blame expensive technological failures for the ailing state of our Health Service or for the fact that the expected age of senility and death is no longer receding. But how much should we expect technology to influence our health and survival? Health care will always be the task of a stone-rolling Sisyphus, because the one condition with a one hundred per

cent mortality is life. There is a limit to what we can achieve. Within these limits, the simple application of some very complex technological achievements has virtually eliminated diphtheria and smallpox, prevented rubella deformities and Rhesus disease in babies, and shown us how to control tuberculosis and diabetes. Alongside this there has been an epidemic growth of lung cancer and cigarette-related diseases, together with an enormous increase in obesity, alcoholism, and diseases of the heart and circulation which can, at least in part, be related to gross errors in our social priorities and our feeding habits. Is this, then, a failure of technology? If we are to apportion blame, let us not forget the failure of political will over the simple issue of cigarette smoking. Should cigarettes be banned in tube trains and other public places or should the issue of discouraging smoking be fudged, because of voting implications and tax revenue? There is now a huge tobacco toll in terms of ill-health and death. Is this a part of "the failure of medical science to increase life expectancy"?

Let it be accepted that some decisions can and should be political rather than medical and let the responsibility for making these decisions be openly acknowledged. Are we able, on a limited budget, to afford unlimited access to the high technology involved in renal dialysis and transplantation, cardiothoracic surgery, artificial joints and computerised tomography? The answer must be no—there are more cost-effective ways of spending at least some of this money. But if hospitals such as Guy's are designated to provide a particular group of specialised services on a regional or supra-regional basis, let us avoid the fiction that these costs can be met from a local budget without causing serious damage to other health care needs of both hospital and district. The Resource Allocation Working Party, in pursuing the worthy aim of equalising health care expenditure between regions, seems to have included a number of "deliberate mistakes". Unless it recognises the extra costs of providing health care in socially deprived, inner city areas, and unless it recognises the need for separate financing of special units, the effect will be an undeclared war on high cost University Hospitals, regardless of whether this will correct the underfinancing of other sectors. Unfortunately, the twin objective of providing both services to the community and centres of excellence is now regarded as a dirty thought. So long as this attitude prevails, the N.H.S. will continue to have problems (quite apart from finance) and the standards of medicine in this country will continue to be threatened.

Yours faithfully,

M. H. LESSOF.

Department of Medicine,
Guy's Hospital, S.E.1.

What is wrong with the N.H.S.?

Madam,

Although agreeing with David Armstrong that within the N.H.S. there will always be different views of what we should try to achieve (ends) and how we should try to do it (means) I cannot agree that this will leave the service "permanently in conflict".

While "conflict" is a label used by sociologists to describe a situation in which there is disagreement over means or ends (or *both* means and ends), its general usage implies a battle or struggle between two sides. I suggest therefore that a more useful way to conceptualise "differences of opinion" is simply to talk about "differences".

The problem is then transformed. Instead of having to think up new lines of attack or defence the problem is to create a system whereby differences can be discussed and a resolution obtained. (Isn't this the essential function of scientific journals?) Such resolution can only be temporary however and it is therefore inevitable that change will be desired. The problem with the reorganisation of 1974 was that its generally bureaucratic nature encourages rigidity—change is very difficult. I suggest that this needs serious attention from social scientists—for it is not a problem that will be alleviated simply by "removing a tier".

Yours faithfully,

JOHN DENNIS

Research Assistant in Sociology Unit
for the Study of Health Policy
Guy's Hospital, S.E.1.

What is wrong with the N.H.S.?

Madam,

Whilst I agree with David Armstrong's conclusion that there "is nothing *fundamentally* wrong with the N.H.S." (my emphasis) I should like to draw attention to a number of problems.

First, many of the difficulties experienced by the N.H.S., and which the media typically present as "LATEST N.H.S. CRISIS", are often more accurately seen as crises of the U.K. *economy* (1).

Secondly, it is important to remember the special difficulties presented to the health service of *any* country which is experiencing a significant change in its population structure. In the U.K., the rising proportion of the old (who of course require more services than those in early adulthood) has been estimated to require ½—1% additional services each year simply to maintain the current average level of provision. *Demographic changes* should not be overlooked.

Thirdly, the N.H.S. has to operate in a peculiarly hostile climate. No manufacturing or commercial organisation—such as the food industry or the building societies—would tolerate for even a week the constant denigration and criticism that for some reason the N.H.S. and its staff apparently have to endure. This is not merely a personal impression of "typical treatment by the mass media". Careful studies of N.H.S. and commercial / industrial reporting show that the media in fact reflect the *opposite* of the facts 2). Whilst the N.H.S. compares very favourably with health services in other industrialised countries, we all know how most sectors of British industry and commerce compare in conventional comparative terms. Yet newspapers carry largely favourable reports of British industry and largely unfavourable reports of the N.H.S.

Finally, I think that increasing size itself should not be allowed to lead to "*concomitant* bureaucratisation" (my emphasis). Indeed, in many ways this is the central issue. The N.H.S. could be a public *service*, and humane and decentralised. Years ago, a few of us at Guy's said that the N.H.S. reorganisers were choosing a bureaucratic rather than a "decentralised, professional" pattern of management (3). Forgive me if I still think we were right. We need more of the "Marks and Spencer approach to management" and less of the bureaucrats' and management consultants' "Elephant rules" philosophy. Industry and public services can be less or more bureaucratic and less or more centralised in character. To accept "concomitant bureaucratisation" seems to me to miss the core of the issue.

Yours faithfully,

PETER DRAPER

Unit for the Study of
Guy's Hospital, S.E.1. Health Policy

(1) "Health, money and the National Health Service", 1976, U.S.H.P. (60p*).

(2) "Health, the mass media and the National Health Service", 1977, U.S.H.P (£2*).

(3) (i) "The future of our health care", 1972, Peter Draper and Tony Smart, U.S.H.P. (50p*).

(ii) "The consultative document; management assumptions versus health care objectives", G. Grenholm and P. Draper, Community Medicine, 21 Jan. '72 (pages 27-30).

(iii) Chapter 8 on N.H.S. reorganisation in "An introduction to medical sociology", edited by David Tuckett, Tavistock, 1976.

*Prices include post and packing.

SPORT

SPORTS REPORT

I received a happy New Year card with the following enclosed. I don't know about happy! (J. J. E.)

1978 Old Bore's Almanac

—predictions for the year 1978.

January. Miserable for Guy's! Christmas pud takes its toll. The weather, so mild for Xmas, suddenly deteriorates when the sporting programme restarts bringing blizzards, hail and rain. A hurricane removes the Rugby stand at H.O.P. Dr. Maurice Yaffé gets together a team of soccer players which loses 7—0.

Dr. Yaffé, Guy's sexologist, misunderstands a free-kick for handball and is sent off for protesting vehemently that his attentions to the opposition full-back would cause no serious psychological problems in the future.

February. 1st XV Rugby team reach the final of the Hospitals' Cup. However, their scrum is kidnapped by opposition finalists St. Mary's and thrown from London Bridge into the Thames. All players are hospitalised after stomach washouts. Captain Graham Francis and ex-Captain Billy Hughes stand in for the scrum but their valiant efforts are overpowered in the final ten minutes. During the after-match celebrations St. Mary's fans burn the goal posts and remove great divots of turf at H.O.P.

The snooker club wins its 17th consecutive match but suffers a military coup and a snooker dictator appoints himself.

March. The soccer 1st XI has to draw its final game to win the league title. The three forwards are so wrapped up in their sweep to see who can be the season's top scorer that they send each other to Coventry and miss all their chances. Andy Mitchell, the captain,

who is rumoured to be Man. Utd.'s next £500,000 signing looks disinterested and goes off at half-time with woman trouble (all his players are performing like women!). The team loses. In the next fourteen days the team completes a Leeds United season losing U.H. and U.L. Cup finals. Paul Shepperd, Guy's 29-goal centre-forward, who just failed to win the Daily Express competition for the scorer of 30 goals reveals he has had secret talks with St. Thomas'. They eventually buy him for three barrels of Youngs and seven guaranteed house jobs for Guy's housemen.

April. The month of A.G.M.s sees Richard Dunn elected secretary of soccer, rugby and cricket clubs. Mr. Dunn asks if he may maintain his outside interests like qualifying in medicine. The snooker club A.G.M. at H.O.P. turns into a riot. The clubhouse is burned down. Mr. Dann complains. Snooker club is taken over by the Southwark Mafia.

May. Tour time. Soccer club is lost in Holland after losing seven consecutive games. "We're no Ajax," Simon Perkins heard to say. The Rugby club wins all its matches but finds it is on the wrong tour. However, celebrations are so magnificent that a new pub is named in their honour.

June/July. The cricket season is with us. Mike Glover scores his millionth run and is signed by Kerry Packer. The team plays well and enjoys modest success until Mike leaves. It is then discovered that they have all forgotten how to bat as Mr. Glover has hogged the bowling for so long. Team collapses. In the summer there is a drought—H.O.P. catches fire and all the pitches are burned.

August. Holiday time. Whilst Guy's is quiet Eric Dann secretly sells H.O.P. for housing redevelopment and emigrates to Argentina where Scotland nearly won the World Cup.

September/December. All Union funds used to buy back H.O.P. so that no money is left to finance sports clubs which inevitably disband.

With best wishes for a happy 1978.

BRIAN BORE.

SOCCER

Guy's 1st XI 8, Icarus 0

A goal-laden start to 1978 was the order of the day against the invitation R.A.F. XI, Icarus.

Although the side was weaker than Guy's have come up against in similar past fixtures, this should not detract from a fine team performance.

Goals were slow to come against the initially strong defence in spite of many fine thrusting runs on the right from Mike Breeze, who from the start gave his full-back a miserable afternoon.

The deadlock was broken when control of the middle was finally taken by Guy's.

The opening goal was put away by Jon Earnshaw after fine work by Breeze and Shepperd. The Guy's back four were tested in the first period, but a return to form for Neil Maclachlan and a powerful performance from Dave Abraham kept Guy's sheet clean. A second goal came just before the interval, expertly "booted" in on the line by Simon Perkins.

The second half saw Guy's caught time and time again by the most simple of offside traps. But in spite of this, Jon Earnshaw was finally put through and scored a fine goal beating the 'keeper well.

Mike Breeze's hard work was rewarded minutes later with a vicious drive after a mazy dribble, a fourth, Jon Earnshaw's "hat-trick", came from a volley one yard out.

Incensed by Jon's tally of goals, the ever industrious Shepperd turned the screw on the now dispirited R.A.F. team and netted three quick goals (one penalty) to keep ahead as top scorer. Dave Rees had a great deal of shooting practise and Andy Mitchell, although as dominant as ever, practised his passing to the opposition.

However Guy's maintained a clean sheet for the first time this season. At last, Nick!

Team: Cowland; Harper, Abraham; Maclachlan, Mitchell, Rees; Perkins, Wilson, Breeze, Shepperd, Earnshaw.

S. P.

RUGBY

Guy's 3 pts., Havant 16 pts.
Fraser Road, 3.12.77

Havant's record prior to this match, of only one defeat, was in stark contrast to Guy's dismal results; however the Hospital put up a brave show at Fraser Road in the face of hostile opposition from players and the crowd alike. Positional changes saw Hughes move to the centre with Hagan returning in the back row, and Broughton moving up to outside-half.

The changes certainly stiffened Guy's defence and gave them more options in attack, and were unlucky not to score a try early on when Hagan was over the goal line but was pushed back out of play before he could ground the ball.

Hughes only took one of three penalty chances and Havant took both theirs to lead 6—3 at half-time.

With the wind and slope against them in the second half Guy's were pushed back on the defensive and Havant's pressure paid off with two tries. Isolated sorties up the field saw Guy's go close but some keen tackling foiled the attempts. With Havant's forwards often guilty of over vigorous play Guy's stuck at their task but their reward was only a narrow but deserved defeat.

Team: Wilkinson, Harris, Owen, Hughes, Francis, Broughton, Laws, Parry, Gibson, Neill, Keevil, Beard, Robertson, Brazier, Hagan.

G. P.

Guy's 8 pts., Sutton and Epsom 21 pts.
Cheam, 10.12.77

Guy's were beaten by a poor side at Cheam; with the Cup so close this result must have given Charing Cross great heart. Guy's started brightly and after going behind to a penalty scored two excellent tries, both times Owen finding extra pace to put Portelly away for his two tries, and that was the last good aspect of Guy's play. With a big slope in their favour Guy's should have turned 30 points ahead even though missing regular place kicker Hughes. Instead they were content to trot around the middle of the field and allowed Sutton to come back with a converted try to lead 9—8.

The second half saw Sutton's simple tactic of kicking high to full-back Wilkinson pay off and Guy's never mustered enthusiasm for an effective reply. Even when chances presented themselves Guy's lack of fitness or handling skills would let them down. Sutton scored regularly and got at least six points out of Guy's back-chatting to the referee. In all a disgraceful performance. Perhaps too many minds were on the Snowflake Ball.

Team: Wilkinson, Portelly, Owen, Harris, Francis, Broughton, Laws, Parry, Gibson, Neill, Keevil, Beard, Robertson, Brazier, Hagan.

G. P.

SWIMMING CLUB

"Water water everywhere, but not a drop to drink". Was this the foreboding that S.C.T. had about the U.L.U. Swimming Gala held last November? It certainly felt like it to the swimmers waiting on the edge of the pool not to mention those in the "drink". However, Guy's managed to keep its head above water in a competitive event.

After a preliminary warm-up, each heat was hotly contested but the water temperature kept things below boiling point. Guy's steamed ahead and the following qualified for the finals on the 2nd day:

Elizabeth Palmer, Mary Ganczakowski, Sara Leutchford, Tracey Maunder, Caroline Kinloch Jones, Christine Smith, G. Teo, Dave Rickard and Mike Miller.

The men's team was a bit of a wash out as the numbers were rather depleted this year but the remaining few did very well helped by the mysterious A. N. Other who entered many events!

Water you think of it so far? Here's a wet limerick for those with a dry sense of humour:

A daring young swimmer from Guy's,
Who wasn't terribly wise,
Dived in the drink
In a Wolfson sink,
And was rapidly brought down to size.

Results

Thirteen colleges of the University of London entered the competition and Guy's effort is to be commended. The ladies' team came 2nd, beaten only by U.C. and the men's team came 4th.

Teams

Ladies.—Christine Smith (captain), Mary Ganczakowski, Elizabeth Palmer, Tracey Maunder, Sara Leutchford, Caroline Kinloch Jones, Sally Brown, Sally Clark, Judith Carlton.

Men.—Mike Miller, Dave Rickard, G. Teo, Nigel Masters, John Taylor.

M.G., K.G., C.M.

HOSPITAL INFORMATION

Newland-Pedley Travelling Scholarship

This Scholarship will be awarded to the holder of a registrable dental qualification, who has been educated at Guy's Hospital Dental School, to enable him or her to undertake a year's postgraduate dental study at one or more Dental Schools or Colleges abroad approved by the Dental Council. The value of the Scholarship will be up to £1,500 and the actual amount of the award will depend upon whether the holder of the Scholarship proposed to spend a year at an institute in Europe or Scandinavia or whether the year will be spent in Canada or the United States. The holder of the Scholarship may be required to undertake teaching duties in this School for the academic year following that in which the Scholarship is held.

Dental Travelling Scholarship

This Scholarship has a value of £250 and is awarded every year to the holder of a registrable dental qualification, who has been educated at Guy's Hospital Dental School, to enable him or her to study at one or more Dental Schools abroad which are approved by the Dental Council.

In order that applications for the Travelling Scholarships may be considered by the Dental Council in sufficient time to enable the successful candidates to make arrangements for travel etc., it is necessary for all applications for Travelling Scholarships for 1978 to be received by the Dean of Dental Studies by Friday, 17th February, 1978.

The Dean of Dental Studies will be pleased to discuss the matter with anyone who is interested.

PAPERS BY GUY'S MEN

Ashley, F. P., Mainwaring, P. J., Emslie, R. D. and Naylor, M. N. Clinical testing of a mouth rinse and a dentifrice containing fluoride. **British Dental Journal,** 1977, **143,** 333-338.

Beeching, B. W. et al. Exposure to scattered radiation in the vicinity of dental X-ray sets. **British Dental Journal,** 1977, **143,** 367-370.

Billings, R. A., Burry, H. C. and Jones, R. Low back injury in sport. **Rheumatology & Rehabilitation,** 1977, **16,** 236-240.

Crome, P., Dawlings, S., Braithwaite, R. A., Masters, J. and Walkey, R. Effect of activated charcoal on absorption of nortriptyline. **Lancet,** 1977, **2,** 1203-1205.

Doyle, D. V., Glass, J. S., Gow, P. J., Daker, M. and Grahame, R. A clinical and prospective chromosomal study of yttrium-90 synovectomy. ***Rheumatology & Rehabilitation,*** 1977, ***16,*** 217-222.

Goulding, R. and Volans, G. N. Emergency treatment of common poisons emptying the stomach. **Proceedings of the Royal Society of Medicine,** 1977, **70,** 766.

Hughes, C. A. Prince, A. and Hermon, R. Factors influencing intestinal mucosal hypoplasia during total parenteral nutrition in rats. A paper given at 38th annual main meeting of the British Society of Gastroenterology. **Gut,** 1977, **18,** 945.

Hughes, R. A. C. Immunological aspects of multiple sclerosis. **British Journal of Hospital Medicine,** 1977, 467-476.

Penfold, D. and Volans, G. N. Overdose of Lomotil. **British Medical Journal,** 1977, **2,** 1401-2.

Watson, J. P., Annear, J. M. and Yaffe, M. Aspects of the psychopathology of sexual behaviour. **Proceedings of the Royal Society of Medicine, 70,** No. 11, 789.

Webb, J. Renal failure associated with ergot poisoning (Correspondence). **British Medical Journal,** 1977, **2,** 1355.

Wyard, S. J. A book review. **Proceedings of the Royal Society of Medicine, 70,** No. 11, 804.

DEATHS

BARWELL—Dr. G. Barwell died on 27th November, 1977.

MARSH—Dr. A. R. Marsh died on 15th December, 1977, aged 74 years.

PRITCHARD—Dr. T. G. Pritchard died on 26th December, 1977.

PUGH—Dr. J. Mostyn Pugh died on 7th December, 1977, aged 56 years.

CHANGES OF ADDRESS

Mr. and Mrs. Stuart Averill, Capel End, Capel, Surrey. Tel. Dorking 711269.

Dr. and Mrs. Christopher S. Drake, "Frenshams", Four Throws, Hawkhurst, Kent, TN18 5EB. Tel. Hawkhurst 2140 (STD 05805).

Sheila and Andrew Fairley, 28 The Fairway, Aldwick Bay, Bognor Regis, Sussex, PO21 4HD. Tel. Pagham 3431.

Peter and Judy Hodgkinson, Greenbank, Boscadjack, Sithney, Helston, Cornwall.

Mr. C. J. T. Howell and Mrs. T. A. Howell (née Teare), 81 Kidbrooke Grove, Blackheath, London, SE3 0LQ. Tel. 01-853 0891. (amendment to change of address shown in October issue).

Dr. Anne Kenshole (Forbath), 14 Donwoods Drive, Toronto, Ontario, Canada, M4N 2G1.

Paul and Sally Liddiard, Caesarea Lodge, St. John, Jersey, C.I. Tel. Jersey 62570—Surgery, Stopford Hall, Stopford Road, St. Helier, Jersey, C.I. Tel. Jersey 74996.

Mr. and Mrs. P. Maxwell Stephens, Quinton Cottage, Bell Vale Lane, Haslemere, Surrey.

Martin and Holly Wheeley, 10 Maryland Court, Rainham, Gillingham, Kent, ME8 8QY.

PERSONAL

LONG ESTABLISHED London, W.1 private practice with three partners requires experienced part-time assistant, initially for two days a week, and with a view to full-time profit sharing partnership. Own laboratory, hygienist and modern fully equipped surgeries. Write Box No. 112/77.

GUY'S HOSPITAL GAZETTE

ISSN No.: 0017-5870 Tel. No.: 01-407 7600 Ext. 2023

EDITOR STEPHANIE A. AMIEL
ASSISTANT EDITOR RICHARD HENDERSON
NEWS EDITORS A. P. J. PINI, S. FENNY & P. J. RAZZELL
NURSING CORRESPONDENT Miss P. M. JEFFERIES
PHYSIOTHERAPY CORRESPONDENT R. J. COOPER
RADIOGRAPHY CORRESPONDENT J. GUEST
MANAGER L. PAYNE

MONTHLY 25 FEBRUARY 1978 VOLUME 93 92 NUMBER 2279

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

THE PHOENIX RISEN

It has been not a wind so much as a veritable hurricane of change blowing through Guy's over the last few years. I refer in particular to the introduction of the "new" clinical medical curriculum—"new" no longer since it is now in its third year and may be said to have reached, at last, its toddler stage.

As with all climatic events, we forecast, we suffer and, if we survive, we analyse. Much has already been written and said on this theme. The uncomplimentary, not to say hostile, views of the students affected by the change over have been vociferously if unprintably expressed. Such hostility was to be expected and was largely justifiable. We have some very beautiful mountain ranges in the world, but I don't suppose the Laramide Revolution that created them was much appreciated by the dinosaurs it destroyed. And undeniably the clinical course has been in chaos during its re-orientation. Students have repeated firms, missed firms and generally felt their timetables directed by happenchance rather than by logical plan. As one example, the timing of curriculum completion with respect to Finals has varied from the sublime to the ridiculous. Last year, there were some four months for locums, revision and assimilation between the end of the senior appointments and the beginning of the dreaded examination, while this year students will be sitting those vital papers a mere eleven weeks after returning from electives and only three weeks after completing their senior medical clerkships. Such anomalies were probably inevitable in the institution of any major revision of the course, and are temporary—applying only to those who were in the middle of their training when replanning began. Temporary for the school, that is—let us not fall into the currently popular bureaucratic habit of seeing only the enterprise and not the individuals involved. Any effects of being educated during the recent unrest may be felt permanently by those who suffered them. One may rebuild a city after

it is flattened by a hurricane and probably the new will be an improvement on the old—but only God can restore the lives of its individual citizens.

However, the last of the old brigade are approaching Finals in April—after which (D.V.) all the clinical students will be under the new marching orders—I beg your pardon, under the new regulations—and all on one course designed to meet those regulations. Finally, after three years of confusion while two courses attempted to run in parallel, the new scheme is emerging in its intended form. What has been achieved?

In fact, a very substantial benefit. The new firms, seen for the first—and last—time by students familiar with the old, are a vast improvement. They are probably very much closer to the original apprentice-style clerkships many of our fathers knew, the loss of which has been greatly, and rightly, deplored. The major and most obvious change has been in firm structure. Small firms with less than a dozen students on each have been created.

Admittedly, this was the promised end to the upheaval. Three years ago everyone was very puzzled to find themselves in groups of twenty-plus, mixtures of seniors and juniors. Had not small firms of students of equal experience been promised? Well, it takes longer for the medical school to alter a clinical curriculum than for an earthquake to create a mountain. Maybe they were not as careless of the effects of the interim as some have thought. And the current firms are splendid. With fewer students, there is naturally a higher student : patient ratio, but perhaps of more significance is the increased doctor : student ratio. As a result of the smaller more intimate firms, students can work more closely with the junior doctors and therein lies the great advantage. Students become directly involved in care of patients and, by attendance on business rounds—impossible with twenty contemporaries—can follow, question and understand their treatment. These increased opportunities for clinical experience are exciting—the reason we came into medicine and the way we will learn.

A caveat. Returning to the quarter century of students still to qualify under old regulations—their problems would have been no greater than those of all others studying during the change period, but for one detail. Apparently the position of Final Examinations on the University Calendar was sacrosanct. Would it really have been impossible to delay the Olde Tyme Finals until June, thus allowing the students involved the incalculable benefit of a final surgery firm? And giving them more time to recover from the elective which incidentally, for all other students, is now in a perfect site. It has been moved to the end of the second year, when students have a clinical background sufficient to give them the confidence and competence they need to make most use of the opportunities they may find themselves. Yet they return in good time for those all important exams.

The storm has settled and the landscape is emerging. It is recognisable—still basically the same course with the same ends—but with one or two mountains thrown up on the old plain. Perfection is an ideal for which to strive and is not yet achieved—but the wind and rain will weather the new mountains into softer outlines in time. Meanwhile we can relax and enjoy the benefits the changing seasons bring.

CONSTITUTIONAL COVER - UP

Members of the Clubs' Union Council are preparing—indeed, have prepared—a new constitution. One change projected is the inclusion of all Guy's physiotherapy and radiography students in one Union, thereby giving them equal rights in its democratic processes. The proposals also outline major changes in the structure of decision making bodies of the Union. Current Union politicians apparently feel they have not enough influence on other bodies—such as S.M.E.C. and the Dental Society—active at Guy's. But perhaps the biggest bone of contention is in the proposal that only students should have voting rights in the Union, effectively reducing staff members to an advisory capacity. Wherein have our staff members offended? Surely their presence in the Union hierarchy has been for good? They provide a continuity in the Union structure that would be impossible for student representatives. And a direct link to administration of the Medical School and Hospital. And, not least, perhaps, a counterbalance to the activists who might otherwise dominate the Union.

Messrs. Denning, Carney and Hughes, these are important changes you are proposing in our Union. May we know more?

S.A.A.

CLINICAL SERIES: ADVANCED SESSIONS

The Advanced sessions of the 4.30 p.m. "Clinical Series" have been designed with the newly appointed House Officer in mind. Subjects are selected on grounds of being . . .

(a) Major *emergencies* which the newly qualified doctor might have to treat, initially on his or her own, or

(b) problems of *practical management* which are seen to be handled poorly by new doctors, or regularly perceived as difficult by senior students, or

(c) matters of major *social, moral or legal* importance which may have eluded discussion in the student's course hitherto.

These sessions should prove highly valuable to senior clinical students.

Pre-registration House Officers might also find the sessions useful or interesting, and they will be most welcome. The venue is the Anatomy Theatre.

March

Thur.	2	The Use of Drugs in Hepatic and Renal Failure (Professor Trounce).	
Mon.	6	Acute Soft Tissue Injuries (Dr. Gibson).	
Tues.	7	The Acutely Inflamed Joint (Dr. Panayi).	
Thur.	9	Which Analgesic? (Dr. Volans, Dr. Kay).	
Mon.	13	Important Interactions Between and Side Effects of Drugs (Dr. Rogers).	
Tues.	14	E.N.T. Emergencies: Major Epistaxis and Vertigo (Mr. Douek).	
Thur.	16	Which Antibiotic? (Dr. Simmons).	
Mon.	20	"The Doctor in Court": The Good Witness (Professor Simpson).	
Tues.	21	Medical Care in Developing Countries (Professor Mins).	
Thur.	30	Fluid Balance and Parenteral Feeding (Mr. Jourdan).	

RED FLU JABS

Guy's students are to the fore in assisting in trials to find an effective vaccine for the current epidemic of "Red Flu". Student volunteers, both medics and dentists, were given vaccines on February 13th as part of a research programme.

NEWS IN BRIEF

New Year's Honours List

We should like to offer our heartiest congratulations to Sir Alan Parks on his knighthood. Sir Alan is Surgeon to The London and St. Marks Hospital. He qualified at Guy's after the War and was a Senior Registrar here in the 1950s.

We also wish to congratulate Mr. J. MacLean, O.B.E., D.S.C.

Congratulations

We would like to congratulate Major-General J. C. Crook, M.D., F.R.C.Path., D.T.M. & H., L./R.A.M.C., the director of Army Pathology, on his promotion from Brigadier.

Guy's Hospital Summer Festival and Sports Day

This will be held on Saturday, 20th May, 1978, at Honor Oak Park. The event will involve both serious and light-hearted sports events, a number of side-shows, extra types and quantities of beer and the day will end with a live band and disco.

President's address

On February 14th, in one of the most dynamic presidential addresses for several years, the new President of the Clubs' Union, David Denning, set out in broad terms his plans for the coming year. He spoke of integrating the physiotherapy and radiography students into the Union and of major constitutional changes at present being examined in sub-committee. He was especially concerned that students should run their own Union, with staff in a purely advisory capacity, and that the Union accounts should be made comprehensible to students. In frank terms he disclosed a deterioration in the functioning and finances of the bar and introduced a new hard line on perenially disruptive elements. Finally he held out promise of better food in the Spit, showing more imagination than at present. This may be the easiest of his tasks. A pungent and apt quote from Machiavelli rounded off this stimulating and controversial manifesto.

Blues Committee

A meeting to elect a new Blues Committee will be held on Thursday, 2nd March in the Committee Room, East Wing. All Full Blues are invited to attend.

Pupils' Physical Society

On Tuesday, 31st January a meeting was held to reform the society and to plan an inaugural meeting. Mark Stringer was elected President and Alastair Jacks secretary of the society. Dr. Brendan Hicks has been invited to become the Honorary President. An inaugural meeting is planned for 2nd March—details of which are given elsewhere in this issue.

Prize Winners, 1977

The Levitt Prize for Community Medicine: Hywel Watkin.

Ruddigore

The Guy's Hospital Gilbert and Sullivan Society present "Ruddigore" on March 1st, 2nd and 3rd at 7.30 p.m. in the Greenwood Theatre. Tickets 50p.

Easter Concert

The Music Club is holding its Easter concert in the Greenwood Theatre on Wednesday, March 8th at 8 p.m. There will be a wide variety of both choral and orchestral works, including Handel's "Zadok the Priest", Britten's "Hymn to St. Cecilia" and Haydn's Symphony No. 104. Tickets price 50p are available from members of the choir and orchestra, in the Colonnade at lunchtimes, or at the door.

Issues in Health Group meetings

Wednesday Workshops—"Health Care in the Community".

Wednesday, 8th March: Marianne Scragg, Midwife.
(In the Reading Room, East Wing at 1.30 p.m.)

Other meetings:

Thursday, 16th March: Colin Blythe, Nutritionist, Queen Mary College: "Eating our way out of debt and disease".

Friday, 5th May: Marshall Marinker, Professor of Community Health, University of Leicester: "Balint therapy—good for patients, better for doctors".

(Both in the Dental Museum, 27th Floor, Guy's Tower at 5.30 p.m.)

As always, I.H.G. meet on Thursday lunchtimes at 1 p.m. in Mollison House (Sociology/Psychology building) to discuss issues and future speakers. All are welcome.

London flooding

The risk of flooding from the River Thames in certain conditions of wind and tide will be with us until April, and thereafter between each August and April until the Silvertown flood barrier is operational. A total of 45 sq. miles, one million people and 250,000 homes, hundreds of factories and some 35 hospitals lie in the risk area—including Guy's. The general policy of Guy's Hospital is based upon the need to maintain patients and staff for a limited period of about 48 hours until evacuation could be organised, and the detailed contingency plans are in the process of re-examination.

Fortunately the flood risk is small—the last serious overtopping of the river in London was in 1928—and it is comforting that the G.L.C., police and our own hospital authorities are well prepared for an event that we must sincerely hope will never happen.

Nurses' meal switch

In the near future facilities for night meals will be transferred from the Nurses' Home to Guy's Tower Restaurant. The change will only affect staff and students on night duty.

Cool weekend

The weekend of 11th-12th February was a chilly one for patients, staff and students alike when the hospital's boilers were shut down to repair a major leak in the high temperature hot water system. Something of the Dunkirk spirit was detectable in the Medical School that Friday afternoon when an armada of plucky little electric heaters was assembled from offices all over the building to be sent onto the wards. In the event contractors brought in an adequate supply of emergency heaters, but for students in Wolfson House it remained a cool weekend. Services were restored on the 13th, though residual problems with the "ancient" heating system in Hunt's House and Outpatients were providing the Works Department with some headaches.

Nordic Symposium at Guy's

For two memorable days, the Guy's Arthritis Research Unit was host to the Second Nordic Symposium in Rheumatology. More than 130 Rheumatologists from Denmark, Norway, Sweden, Finland and Iceland attended the meeting, which was chaired by the Director of the Arthritis Research Unit, Dr. Rodney Grahame. The theme was "Trends in Drug Treatment in Rheumatic Diseases". Nineteen papers, all to be published in a forthcoming supplement to the *Rheumatology & Rehabilitation,* were presented in five sections. The latest thinking on pathogenesis and modes of drug action in inflammation in joint disease (Thursday, 9th February); on the use of non-steroidal anti-inflammatory agents, gold and penicillamine; and on possible drug interactions and side effects encountered during the treatment of rheumatic disease (Friday, 10th February) was produced and discussed. The symposium was concluded after a panel discussion on drug trials.

Film Society

The Film Society at Guy's is showing a programme of films this year which will appeal to a wide audience, and although it is primarily a student society, staff at all levels within the Health District are very welcome to attend. The films are shown in the Physiology Lecture Theatre, Medical School building and the price of admission is 40p. Here are some forthcoming programmes:—

Thursday 2nd March—Straw Dogs.

Thursday 27th April—Death Wish.

Thursday 11th May—Man Who Fell To Earth.

Thursday 25th May—Double Indemnity.

Thursday 8th June—Road to Morocco *and* Horse-fellers.

Closing of the Book Exchange

Due to lack of demand over a period of years it has been decided to close the Book Exchange as soon as possible. All outstanding accounts will be paid in March. Currently the Exchange is holding over 100 books, some of which have been here for many years. The Exchange will be open from 1.15 to 3.15 p.m. on all weekdays except Wednesday until the end of April. Books unclaimed at the end of this period will be disposed of and the proceeds given to charity

Dates from the Medical Diary

Wednesday, 1st March—Examination for the Treasurer's Medal and Tewfik Prize in Surgery begins. Examination for the School Prize in Pharmacology begins.

Friday, 3rd March—Entries close for the Treasurer's Medal and Prize and Baldwin Prize for Clinical Medicine.

Wednesday, 8th March—Examination for the Treasurer's Medal and Prize and Baldwin Prize begins.

Friday, 10th March—Entries close for the Gillespie Prize in Psychological Medicine.

Wedensday, 15th March—Examination for the Gillespie Prize in Psychological Medicine begins.

Thursday, 16th March—Basic Medical Examinations (5th term) begin.

Friday, 17th March—Entries close for the Beaney Prize in Histopathology.

Monday, 20th March—Basic Medical Sciences Examination (2nd term) begins.

Wednesday, 22nd March—Examination for the Beaney Prize in Histopathology begins.

SPRING TERM ENDS—Medical School closed on Friday, 24th (Good Friday) and Monday, 27th (Easter Monday).

Dates from the Dental Diary

Friday, 10th March—Applications for the Final L.D.S. Examination, Parts I and III (obtainable from the Medical School Office) must be left in the Medical School Office not later than this date.

Monday, 13th March—Applications for the First L.D.S. Examination (obtainable from the Medical School Office) must be left in the Medical School Office not later than this date.

Friday, 17th March—Applications for the Third B.D.S. Examination, Parts I, II, III, IV and V (obtainable from the Medical School Office) must be left in the Medical School Office not later than this date.

Thursday, 23rd March—Entries close for the Preliminary Examination for Studies in Medical Subjects.

Greenwood Conference

On January 12th, the Greenwood Theatre was the venue for a big press conference. The conference was held to launch a new product designed for use in the treatment of leg ulcers and other wounds. The Greenwood provided comfortable—even luxurious—surroundings for the guests.

CLUBS' UNION NEWS

Overview

Generally speaking it is not difficult to win uncontested elections. And certainly in this case it is not profitable to spend hours speculating as to the reasons for no opposition. But with all that said and done, I now carry the honourable and onerous task of being the principal representative for all medical and dental students at Guy's, both within the hospital and outside.

The role of the Clubs' Union is primarily an administrative one. It allocates money from its annual income of £27,000 to all the clubs, and the Athletic Ground at H.O.P., along with various other expenses, besides maintaining a credit balance. It organises social functions and runs the bar. The rooms in Boland House (East Wing) come under its jurisdiction. It sends representatives to various internal committees including School Council and Dental Council, to Catering and Hostels committees and other specialised committees which include the *Gazette* Committee. Being a college within London University it represents our students on committees dealing with sports leagues, education, even political issues such as the Benyon Bill or health service cuts.

But it also cultivates policy of its own. The main points of the trust during the coming year can be summarised thus:

(1) Rationalisation of educational representation both internally and externally. At present the Student Medical Education Committee (S.M.E.C.) and the Dental Society deal with these matters internally and the Clubs' Union has this responsibility externally.

(2) Research into the possibility of amalgamating various student unions, e.g. the Physiotherapy Union into a modified Clubs' Union.

(3) The car parking situation at Guy's is appalling. Negotiations are in progress to relieve the problem, at least to some extent.

You will be hearing from me monthly when I hope to deal with specific issues as they arise, or projects as they approach maturation. Until then, wish us all good luck.

David Denning,
President, Guy's Hospital Clubs' Union.

The Students' Bar

It is with sadness that I find myself writing such a depressing article at the end of my year of office as the Bar Secretary. It is without doubt the most thankless and disillusioning of all Union posts. It is said that you get out of a job as much as you put into it but in this job it is definitely the converse which is true.

However, let me state first of all what has been achieved. This year has seen the arrival of an efficient ice-making machine, the second glass washing machine and a second cooler tray. Also a fruit juice dispensing machine has been installed. Spot lights have been on order (for the past six months!) for the table football machines and, when we have sufficient funds, a darts board will be built. Special functions in the ballroom are now accompanied by at least a beer bar and it is hoped to extend this facility in the future. It can now be said that all necessary redecoration to the

As a Naval Medical Cadet you'll get a lot out of life. £2,636 a year for a start.

If you have passed your 2nd MB (or equivalent) and you pass our selection board, we can offer you £2,636 a year for your final three clinical years.

You can spend your elective periods at a Naval hospital in the UK or abroad.

And, after qualifying, spend your pre-registration year at your own teaching hospital or in one of the recognised posts at our UK Naval hospitals.

On registration, you will start your 5-year Short Service Commission as a Surgeon Lieutenant.

At sea.

After a short Officers course at the Royal Naval College, Dartmouth, and a basic course in maritime medicine at the Institute of Naval Medicine, Alverstoke, you will normally go to sea for about 12 months.

You will be responsible for the medical care of some 250 to 500 men in your ship (and advise the Captain on health and environmental problems).

You will not lose touch with modern medicine, as you can visit local hospitals in ports of call and use the teaching aids provided by your Naval tutor.

Postgraduate training and specialisation.

After your sea-time, career counselling will determine your postgraduate training programme.

There are opportunities for General Professional Training in preparation for a clinical career in general practice, the hospital specialities, or the medical scientific disciplines such as Aviation, Underwater, Submarine and Nuclear Medicine; or in Occupational and Community Medicine.

If you decide to transfer to a 16-year pensionable Commission, or a permanent Commission, you could move on to recognised higher training programmes which include research training and higher training posts in civilian units.

At Alverstoke, the Dean of Naval Medicine co-ordinates postgraduate medical training and research.

Naval hospitals.

The two largest are at Haslar (near Portsmouth) and Plymouth. They undertake the care of Naval personnel, their families and NHS civilians, providing a broad spectrum of clinical material. Both hospitals are recognised for higher training in the major specialities.

There is a full range of modern, technical equipment, and the nursing and para-medical staff are highly skilled.

Salary.

As a Surgeon Lieutenant, your basic salary on registration will be £6,517, rising to £7,236 after 4 years.

At the end of your 5-year Commission, you can leave with a gratuity, and possibly with higher qualifications.

Or you can apply for a 16-year pensionable Commission or a permanent Commission.

The salary structure is based on an analogue computed from the average earnings of general practitioners in the NHS, with an additional X factor. There is extra pay for recognised post-graduate qualifications and Senior Specialist or Consultant status.

If you are posted overseas, you can, of course, take your family with you.

For more information, write to Surgeon Commander H.B. Blackstone, MRCS, LRCP, MRCGP, RN, (26GR), Medical Directorate General (Navy), Ministry of Defence, Empress State Building, London SW6 1TR.

bar is completed and this poses the question as to what should become of the bar profits? Well up until August the profits had been used to pay for the improvements and our remaining debts to the Medical School for the stocks which now at last belong to us. A small reserve is necessary for repairs but it was my intention to use future profits to subsidise beer prices as soon as they next went up. However, that time has now arrived and sadly we have no money with which to subsidise beer. Since August, although not actually making a loss, the bar accounts are short of £2,853. If I knew for sure where the money had gone I would have sorted it out long ago. The Bar Committee decided that the shortages were probably due to "Guy's Halves" being served and so they authorised the purchase of the measured half-pint dispensers. These have not been without their teething problems but I hope they will be functioning correctly very soon. It is my opinion that this will not solve the problem and the solution is just as far off as before. It is now time for you, the customer, to come forward and tell the highest authorities if you see any free drinking or thieving going on. It is your bar and you are the only ones who will suffer. Matters are not helped by the continuing vandalism in the bar by irresponsible lunatics. Not only is it unpleasant to drink in the bar at such times but it is impossible to relieve oneself in the urinals as they have been destroyed five times in the past eight months. People in the bar or nearby must see or hear what is going on and when they do I implore them to report it immediately to the Medical School otherwise the situation will continue to deteriorate.

Those who have worked with me this year will know exactly how much effort I have put into this job and seen most of it wasted in the space of a couple of months. The incoming Bar Secretary has a mammoth task ahead of him. He will only be able to do his job if you help him so please give him all your support. I wish him luck. Richard Johns.

WHAT S.M.E.C. THINKS

Paul O'Hare, Chairman, Student Medical Education Committee

Two issues have occupied the committee since the start of 1978; the relationship of S.M.E.C. and the Clubs' Union Council, and the questionnaire concerning the first clinical year.

S.M.E.C. and the Clubs' Union

The relationship between S.M.E.C. and the Clubs' Union Council was first raised in the November meeting of S.M.E.C. The outgoing President said that there was little communication between S.M.E.C. and the Clubs' Union Council, and that while there was a S.M.E.C. representative to that Council no member of the Clubs' Union sat on S.M.E.C. in a reciprocal arrangement. He argued that the Union dealt with many of the London University student education committees and had contact with other Universities and that it was important to have better liaison between the Union's "external" contacts and S.M.E.C.'s concern for internal educational issues. The inevitable sub-committee was set up to look into what appeared to all a reasonable request. As yet, S.M.E.C. has not received the official report from that sub-committee, but the grapevine and popular press indicate that as well as the suggestion that a member of the Clubs' Union Council sit on S.M.E.C. there should be in addition a constitutional "reshuffle" of the whole Clubs' Union, and that the member sitting on S.M.E.C. should be no less than a "Vice-President".

Students must decide about the proposed reshuffle of the Clubs' Union for themselves, and the decision should be made independently of the issue

as to whether a member of the Clubs' Union Council should sit on S.M.E.C. In my view, S.M.E.C. exists to serve solely the educational interests of medical students through its elected representatives It has a unique position in being able to elect student members to all of the important sub-committees of the School Council which are involved in running the medical course. It can thus put student's views on their education to the very hub where decisions affecting teaching are made.

No to politics

To maintain its credibility and its unique position S.M.E.C. must remain totally apolitical, both in the sense of National and Clubs' Union politics. It must remain an independent elected body where students vote for their representative for that year because they feel his views on their present medical education accord with theirs, or that he will put forward theirs as well. The recent involvement of S.M.E.C. as a lever in Clubs' Union politics is something I would deprecate. The issue of a Clubs' Union representative sitting on S.M.E.C. is something that began and should have remained a separate issue.

Questionnaire analysis

Most of S.M.E.C.'s time in the last month has been involved in distributing and collecting in the First Year Medical questionnaire. We hope to have the results and an analysis by the time of the next *Gazette*. Inevitably when a questionnaire is put out, some will object to the results claiming it was biased. If by the term bias one means that the questions concentrate on certain proposed changes and their consequences, then it is, but we think the term *limited* is more appropriate. Every effort has been made to exclude any bias within each question asked and alternatives for the status quo exist for each. We concentrate on the length of time of the medical and surgical firms, the Pathology course, the concept of introducing more "shadowing", the two week introductory course to the 2nd clinical year, and the 1st year systematic series.

REPRESENTATIVE ROLE OF THE DENTAL SOCIETY

Many people at Guy's feel that the Dental Society provides inadequate representation for Dental students. I think that this is due to poor communication between the Society and students, and not (as some like to believe), due to any lack of willingness on the part of the Society to do its job. The increased compartmentalisation which the move into the Tower brought has caused this chronic problem to flare into an acute phase. We are, therefore, at present examining ways in which we can enhance the rapport between the Dental Society management committee and the student body. For example, would a regular newsletter help to fill this large deficiency? In recent discussion between S.M.E.C., the Clubs' Union, and the Dental Society, it was realised that greater co-operation between these bodies would benefit all of us at Guy's.

The first tangible results of this closer relationship with the "Union" has been joint Union/Dental Society representation at B.D.S.A., U.L.U. Dental Group meetings, and we hope, later this year at an N.U.S. Dental working party. Finally, feedback from dental students is an essential part of any representative role that the Dental Society undertakes, and is therefore always very welcome.

Francis Collier,
Secretary.

QUODLIBET SOCIETY

Robert Gittings on Keats

January 26th, 1978

Robert Gittings spent ten years of his life studying Keats, and from these years came some of the most interesting and respected work ever done on the poet. For the last ten years he has been concerned with Thomas Hardy, whose revival in our nostalgic urban society has put him once again in the public eye. Claiming that his notes on Keats had been gathering dust for the last ten years, he managed nevertheless to produce a talk that was both lively and imaginative. As he alternated between an ex-Cambridge don's thoroughness and a more worldly variety of charm and wit, he painted a picture of the poet which was entirely new to most of us.

Considering that Keats spent five out of his twenty-five years in medicine, and only four writing poetry, it is surprising how few critics have pointed to the importance of medicine in the poet's life. His ambivalence towards the two vocation is suggested by his references to Apollo, who was god of both. It is significant also that his decision personally to look after his brother Tom, who was dying of T.B. was itself the cause of his own death some two and a half years later.

It is as difficult to understand why Keats, with his strange background, should have gone into medicine as it is to understand why he became a poet. There were certainly no family "contacts" in either. He may have picked up an interest in the subject when nursing his mother, who died of T.B. when he was thirteen. Anyway, he was apprenticed to the surgeon and apothecary Thomas Hammond in 1811 and entered Guy's in 1815. His coming to Guy's may not have been so much a voluntary act as due to the need to fulfil the requirements of the recently introduced 1815 Apothecaries Act, which meant that he had to spend 6 months at a teaching hospital before he could qualify.

Guy's in 1815 was somewhat different from today, as witnessed by the story of the patient who decided not to undergo an operation after being given the usual alcoholic anaesthetic, and was chased in his hasty retreat from the operating room by a jeering band of 200 students. All the same Keats fitted in well, and in spite of his Byronic dress and physique, his views on life and sex were very typical of any medical student's. Indeed his later descriptions of Fanny Brawne appear analytic and clinical rather poetic; "she has . . . good but painful nostrils, a pale thin face, good arms and tolerable feet . . .". This was at a time when outsiders described Guy's as a "snug family party", and yet Keats was able to penetrate the party to the extent of becoming Astley Cooper's dresser. How he managed to get the job is a matter of great speculation. Robert Gitting's theories on this point ranged from the fact that his name was similar to that of the stern headmaster of Eton at the time (Keate), to the possible effects of Keats' "boyish good looks".

Having qualified, Keats never practised, and gave up surgery altogether. His reason according to his own account was that at his last venesection, he had suddenly realised the consequences of his knife slipping.

For the last four years he went on as everybody knows to become a great romantic poet, whose reputation, unlike those of his contemporaries, has risen ever since. One can only conjecture what he might have achieved if he had lived beyond the age at which most of us qualify, and whether he might not have returned to the business of healing at a later date.

M. D. D.

SPECIAL DEBATE—"Race and the law"—*February 9th, 1978*

". . .Society is as decent and democratic now as it is ever likely to be" argued the leading article of last month's *Gazette*. Can we afford to be so complacent? These assumptions were contended when 60 or 70 people turned up at the Anatomy Theatre to assist in the dissection of the motion: "The law has no part to play in solving the race relations of this country".

Six speeches had been commissioned from a barrister, a solicitor, a radio producer, an actor, and our own Clare Vaughan and Francis Hughes; and ten jokes and six apologies had been duly proffered. Those mistrustful of rhetoric were no doubt reassured by the informality of the speakers and charmed both by their jests and gestures, but were probably a little relieved when eventually Clare Vaughan provided a concise argument against the motion: namely that legislation is indispensable for the protection of repressed minority groups, and that by "dictating social norms" it promotes wider reforms than those insisted on by the letter of the law. Simon Levene had earlier also argued that the law was a crude but necessary method of curbing racialism "with which it is impossible to reason".

Francis Hughes did not wholly disagree, but argued that on the other hand legislation is liable to exacerbate racial tension when the "right of the individual to act freely" is frustrated. Thus the National Front consider that the Race Relations Act gives them their "first real chance to gain power", according to Humphrey Walwin who also spoke in support of the motion. Andy Thomas argued that xenophobia invariably derives from conditions of socioeconomic stress, and that the Race Relations Act is therefore peripheral to the root cause of racial tension.

The open-mindedness of the speakers was evidenced by the fact that all tended to teeter over to the other side of the motion, and by the time the debate was opened to the floor two broad areas of concensus were apparent. Firstly, that the abuse of minority groups must be prevented by some means or other, but that the law is an ungainly method of achieving this; and secondly, that racial prejudice thrives on ignorance. Jo Blatchely had studied the literature of the National Front in order to prepare his part in the recent televising of David Edgar's play "Destiny", and in opening the floor debate he spoke of how that organisation strove to "manipulate and exploit the fears of normal people", turning ignorance into hatred with sufficient skill to challenge our complacency. He urged that it was high time to fight back.

Speeches from the floor covered several important points. It was remarked that if repressed groups are unable to protect themselves by recourse to Law, they may be forced to resort to violence: to this, it was replied that in practice the Law offers little protection against the covert discrimination still frequently practised by landlords and employers. Alison Brookes thought that as long as the Law diminished overt prejudice it would be doing something to improve race relations; whereas another speaker saw the Race Relations Act as little more than a public relations exercise and a sop to the liberal conscience. With a *tour de force* of flamboyant oratory, Mark Polson wound up the debate by regretfully concluding that in this poor substitute for an ideal society "legislation is needed as an interim measure". The House appeared to agree, and the motion was defeated by 32 votes to 10.

The archetypal medical student is often considered a creature of rather narrow mentality. Debates of this sort tend to belie that characterisation; and the cogency of speeches from the floor on this occasion was promising for the future of Discussion at Guy's. D.K.

VACCINATION AGAINST DENTAL CARIES

Dr. S. J. Challacombe of the Department of Oral Immunology and Microbiology answers some questions concerning dental vaccination

Could you explain how a vaccine is intended to work?

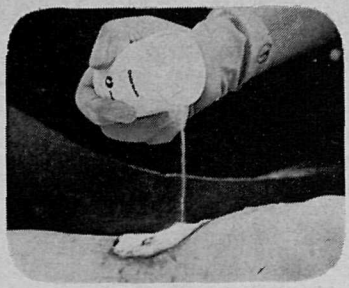
Dental caries is essentially the destruction of enamel by acid and other products of certain bacteria. Recent microbiological investigations indicate that the majority of caries in man is associated with a single species of bacteria—*Streptococcus mutans*. We can therefore concentrate our immunological assault on this organism. A vaccine is intended either to prevent colonisation by *S. mutans* or reduce the numbers if already present. Theoretically a vaccine directed against the enzymes responsible for acid production could be effective without actually reducing the numbers of the organism.

Will a vaccine be effective against both caries and gum disease?

No. One of the fundamentals of an immunological approach is specificity and this applies to virtually all vaccines currently available. At this time we are working on a vaccine using cells or antigenic extracts from *S. mutans*. Unless there are antigenic cross-reactions with other bacteria, we would expect that only *S. mutans* would be affected by immunisation. While there is much evidence to associate *S. mutans* with caries, there is no evidence at all to suggest that this organism is in any way involved in the pathogenesis of periodontal disease. In fact, periodontal disease is associated largely with gram-negative bacteria and the immune response in this case may be damaging rather than protective.

Is Strep. mutans *the only cariogenic organism and if eliminated would other cariogenic organisms take its place?*

Strep. mutans is certainly not the only oral organism that can cause caries in animals. It is however closely associated with caries in man. It appears to be highly cariogenic not only because it can produce sufficient acid to dissolve enamel but also because it produces extracellular polysaccharides, many of which are insoluble in water (and saliva). These polysaccharides appear to help maintain the acid in contact with the teeth and contribute to the integrity of plaque. Other bacteria, such as *Lactobacillus casei* and *Strep. sanguis* which also produce acid and can cause caries in animals, do not appear able to produce this insoluble extracellular polysaccharide. Although *Strep. mutans* is not the only cariogenic organism, it seems unlikely that its elimination would allow other cariogenic organisms to take its place for two main reasons: —Firstly, in humans natural immunity is associated with high levels of serum antibodies to *Strep. mutans* and little or no detectable *Strep. mutans* in their plaque. Other bacteria able to cause caries in animals appear to be present in normal numbers but do not cause caries in these subjects. One can therefore regard plaque with little or no *Strep. mutans* present as the natural situation. Secondly, in monkeys who are allowed to develop a cariogenic flora on a human type diet, immunisation with *Strep. mutans* results in a 70-80% reduction in caries and a reduction in the number of *Strep. mutans*. If caries were caused by other organisms taking the place of *Strep. mutans*, no reduction would be expected.



1978

DEBRISAN

marks the

HEALING

turning point in

THROUGH

wound & ulcer

CLEANSING

treatment

Debrisan is available as a castor containing 60 g of sterile dextranomer.

Further information available on request to the company.
Product Licence No. 0009/0021 Debrisan is a registered trade mark.

Pharmacia (Great Britain) Ltd.,
Paramount House,
75 Uxbridge Road,
London W5 5SS.
Telephone: 01-579 0102/7

Pharmacia

How long does immunity last in immunised animals?

We have now reached the stage where effective protection against caries can be achieved for well over two years with two subcutaneous injections. Immunity probably lasts for longer but expense does not allow us to maintain the experiments for longer than this so far. Optimistically, one would hope that humans might be immunised annually or less if these results were applicable to man.

At what site would you immunise?

The tooth surface is perhaps in a unique site in that it is exposed both to the secretory immune system acting via saliva and to the systemic immune system acting via crevicular fluid. Theoretically, either of these systems might be effective and you can choose your site of immunisation to stimulate preferentially one system rather than the other. Various American groups working with rats have been able to achieve protection against caries by immunising near the salivary glands. In contrast our studies in humans and our work in rhesus monkeys indicate that serum antibodies are effective. We therefore immunise subcutaneously aiming to induce serum IgG antibodies.

How effective is your vaccine in monkeys and how applicable is this to humans?

We have been working on the vaccine for a number of years and can consistently obtain between 70-80% reduction in caries in immunised animals. Most of this has been achieved in the deciduous dentition, but we have recently reported a similar reduction in the permanent dentition. Any animal system can of course only be a model for humans. However the rhesus monkey is a particularly relevant model for humans because of its many similarities to man. The dentition, oral flora and immunological systems in man and monkeys are essentially similar. We have tried to make our model more pertinent by feeding the animals on a human type of diet containing 15% sucrose. This includes peanut butter or jam sandwiches, cheese, sweets and biscuits. Under these conditions, just as in humans, there is a natural overgrowth of *S. mutans* and caries appears in 4-5 months. Differences in caries between immunised animals and controls is detectable after about a year and more evident by the end of two years. Although there is no substitute for man himself, we hope that the results obtained using this system would be applicable to humans.

How long do you think that we shall have to wait for clinical trials in man and are you confident that a vaccine will have no serious side effects?

Anyone working on vaccines is very aware of possible side effects, particularly with the current public discussion on whooping cough and measles vaccines. Obviously any such side effects of vaccination against dental caries are being closely examined. At the present time, no untoward side effects have been detected. A vaccine would not be tried in humans until we or others were very confident on this point. This means that any clinical trials in humans must be delayed until all the possible side effects have been examined. In addition, not all of the antigen and adjuvant preparations that we have used in monkeys would be able to be used in man, and toxicity experiments in man must precede clinical trials. Since each experiment takes approximately two years, a clinical trial could not be undertaken for a few years.

What are the major research problems at the moment?

Some of these have already been mentioned. A major problem is how to achieve the maximum protection with the minimum immunising dose. In our model, protection seems to be mediated by serum antibodies acting via crevicular fluid. This is the fluid which surrounds the necks of the teeth. This fluid contains antibodies of IgG, IgA, and IgM classes. Not all antibodies may be protective and in fact with certain antigens it has been possible to immunise and *increase* caries. The interaction of the different immunoglobulin classes is therefore a major current interest, since the relative amounts of the different classes may be important. In addition the antigens of *S. mutans* against which the antibodies are directed are being thoroughly investigated. Many of the antigens appear to be irrelevant as far as protection is concerned, and the identification of the most important ones may lead to a more effective vaccine. Although immunised animals (or humans who have been immunised naturally) have significantly lower numbers of *S. mutans,* the actual mechanism of this reduction has not been fully identified. The most effective adjuvant, dose and frequency of immunisation are also being investigated.

At what age and on what scale would patients be vaccinated and what sort of impact might this be expected to have on the nation's health?

Clearly one can only extrapolate from animal work in general terms. Vaccination is likely to be most effective at a time when the immunological system is reasonably mature and when there is least challenge from the infecting organisms. This means that the optimal time of first vaccination is likely to be before the deciduous molars erupt.

Comments on the impact of vaccination can only be speculative. After all, with reasonable control of dietary sucrose, reductions in caries incidence of great magnitude could be expected. Indeed the adjustment of fluoride levels in water to 1 part per million over the country as a whole would lead to a 70-80% reduction in caries and save the country over a hundred million pounds. Unfortunately, neither of these measures has found general public approval. A dental caries vaccine would give people a choice of preventive measures, but the efficacy of a vaccine in man must await trials in man.

NOTICE

Pupils' Physical Society

The inaugural meeting of the Pupils' Physical Society will be held on Thursday, 2nd March at 1 p.m. in the Gordon Museum Theatre. Tea and refreshments will be available. The following papers will be presented and the meeting will last one hour.

Rino Cerio, B.Sc.: "Minimal change nephropathy—an immune complex disease?"

Clare Vaughan, B.Sc.: "Personality and Play."

Michael Dixon, B.A.: "High density lipoprotein, fibre and heart disease."

All students and interested members of staff are welcome.

Alasdair Jacks, Secretary.

HEALTH CARE IN CHINA

By Dr. Robin Stott, M.A., M.R.C.P.
Consultant Physician, Lewisham Hospital

Why China? Cultivating an eccentric interest, becoming the undisputed expert, startling colleagues with polemics? None of these things. China offers us pertinent parallels which can inform and nourish our ideas on the direction and organisation of our health service. China's health system is a system from which we can learn lessons.

Health care in China, as indeed everywhere else, reflects the political aspirations, priorities and ideological sentiments of the country. Chinese communism places great emphasis on self-reliance, commitment to communal rather than to individual goals (not that these two are mutually exclusive) and involvement of as many people as possible in the organisation and practice of all aspects of their lives. This last is reflected in the "Mass Line" approach, which has been particularly useful in solving their health problems, but all facets are incorporated into the present health care system. Health objectives were first formulated in the 1920s and 30s, the early days of the revolution, and were first recorded at the National level in 1950 during the first National Health Conference. There are four main objectives:

(1) Medical care should be preventive not curative orientated.
(2) It should be directed particularly towards the poor and middle peasants, soldiers and workers (the 95% of China's population formerly without health care).
(3) There should be a creative interchange between traditional Chinese and Western medicine.
(4) The Mass Line should be used to advance health care.

From the early 30s, until the formation of the PRC on 1st October 1949, the communists organised many base areas in China and had ample opportunity to refine their policies according to practical results, so that there was a wealth of experience available when the policies became countrywide in 1950. However, problems arose as inevitably they must in the revolutionary transformation of a society. From 1950 to 1966 a great ideological debate developed in China. The question was how to further socialism now that state power was won? Should a trained elite drag up the level of society, after the Russian fashion, or should specialist information be given to ordinary people so that they themselves could transform their society, the Maoist view. The cultural revolution which began in 1966, was the culmination of this struggle, and the later view prevailed. During the cultural revolution medicine was particularly singled out as having strayed furthest away from the Maoist line and with the cultural revolution came several changes. Although much had been done prior to 1966, the impetus of the cultural revolution was vital to the more thorough going implementation of the health objectives spelled out in 1950.

First the actual structure of health care changed. The basic level of health organisation became the brigade or neighbourhood clinic. These two are the smallest administrative units in the countryside and town respectively, having a population of up to 2,500. Bare-foot doctors run these clinics, which are concerned with most aspects of personal and public hygiene, contraception and therapy for most common conditions. Street or Commune Hospitals (the next administrative units of approximately 25,000 people) are the next layer up. Doctors trained in both Western type and

Chinese traditional medicine work here and there are basic inpatient, pathological and radiological facilities. Simple operations and medical problems are dealt with here, and it is the first reference point for bare-foot doctors. District hospitals, with similar functions to ours, serve populations of up to 500,000, and cope with much the same range of illnesses as our district hospitals. They are in comparison sparsely equipped, however. At the apex of pyramidal structure come the teaching hospitals. Each province and large city has at least one of these. They have the same role as our teaching hospitals, but pervading these hospitals, as well as levels of health care, is an emphasis on the primacy of the bare-foot doctor as the leading edge of health care.

Doctors working in the fields.

The form of a country's health service illuminates that country's aspirations, but we have to judge by the content and results. To get an inkling of the contents, I will elaborate on several changes which occurred during the cultural revolution which moulded the attitude and activities of many health workers. Many of the eight changes I will describe relate to other areas of the life as well as health, but I will concentrate on the health aspects.

(1) Bare-foot doctors were first trained in large numbers in 1966 and 1967 and are people who have minimal basic education. They are chosen by their own work unit for medical training, which may last up to six months and is undertaken in hospitals. They then return to the same work unit and productive role from whence they came. Their doctoring is an additional commitment. Because of the continued close association with their workmates, barefoots can deliver appropriate health care and propaganda with maximum efficiency. Those that I met had a level of competence far in excess of what we would expect after only six months of training and are evidently competent so far as basic preventive medicine is concerned. There are now over one million bare-foots among China's 800,000,000 population. Many of them are women and most have regular refresher courses to keep them in touch.

(2) Medical Education was shortened from six to three and a half years and made more relevant and practical.

(3) Each doctor was to some extent trained in both traditional and western type medicine, thus cementing an, up till then, uneasy linkage. From this liaison have come the novel orthopaedic treatments, acu-puncture anaesthesia and a widespread use of, and an investigation into, herbal remedies (these are inexpensive, usually harmless, and are at least admirable placebos). Herbs are cultivated by many schools, communes and factories, and their use greatly diminishes the drug bill.

(4) Student selection was altered. High school graduates now do a two year stint in either a factory or commune, and are then assessed for their community interest and selflessness by the other members of their work-teams. After passing this selection hurdle, the aspirant would then be subject to conventional assessment before being admitted to university. This process widened the base of student selection and ensured that the students were appropriately motivated to serve the people on completion of their training.

(5) A policy of open door research was instituted. Local people are encouraged to feed in relevant problems for consideration and are then involved in gathering data, and evaluating procedures and findings.

(6) Cadre schools, where non-manual workers spend up to two years, were opened. Whilst at these schools incumbents provide for themselves, they learn from the local workers and peasants and through this interchange learn the true health requirements of ordinary people. Health workers also spend a regular session each week doing manual labour.

(7) The number of mobile medical teams was greatly increased. Such teams, made up of all types of medical workers, would travel to remote areas both to disseminate medical skills and to learn the requirements of the people.

(8) Hospitals, like all other organisations, came to be run by a revolutionary committee, elected by all members of the hospital from among their work mates. There is also an input from the community, the local Communist Party and in the early days, the Peoples Liberation Army. This last group is now not necessarily represented. Major problems are discussed widely before decisions are reached, and the hospital staff feel involved in, and responsible for, such decisions. A member of the revolutionary committee can be replaced by a simple majority of the staff voting for this.

The emphasis on involvement of unskilled people in health care, health workers learning from the people, and the blurring of traditional roles and status of doctors has ensured that health care reaches all areas of China. It enables bare-foot doctors to get maximum support, and, in contra-distinction to auxillaries in many other places, equal status. Threading through all this is the use of the mass line in medicine and to illustrate this, I will describe how the Chinese people tackled schistosomiasis. This was endemic in the Yangtze basin and around Canton, and parasitologists went to various villages in the endemic areas and explained to the villagers the nature of the disease. The question asked was how can we, with our few resources and our extensive waterways, cope with this disease? After much discussion everyone felt the right thing to do would be to kill the snails. The scientists then said this could be done by burying them under nine inches of soil and also pointed out that snails lived on the waterline. Villagers, with their understanding of the irrigation system, drained these channels systemically and dug over the snails. Thus with a sharing of knowledge, motivation, mass

Blind women working in a factory for the disabled.

participation and hard work, the snails were destroyed. These measures may have to be taken again, and the people are resolved to do this if necessary. The elimination of syphilis offers another example of the working of the mass line. Venereologists went to several villagers in Honan province. After discussion, some villagers were chosen to learn how to recognise syphilis clinically, do a simple screening test, and treat the disease. They went about the task, and when satisfied, the specialist came in to check and discovered a 95% success rate. The pilot scheme was thus extended to all parts of China. Of course, any initial diffidence on the part of a victim was dispelled by the stratagem of saying that syphilis reflected imperialism and feudalism, not individual morality. With the slogan "we can't carry syphilis into socialism" the ideological battle was won.

The mass movement approach coupled with an adequate food supply and improving personal and public hygiene have effectively eliminated cholera, typhoid, typhus, and much reduced tuberculosis and malaria. Other diseases are largely controlled by their immunisation programmes (the list is formidable, including polio, smallpox, diphtheria, Japanese B encephalitis, measles, whooping cough). Contraception and abortion are readily available, most people have easy access to medical care, and as new problems are identified, the system is well suited to deal with them.

Modern Chinese society is caring and participatory, and I would expect this to reduce the incidence of neurotic disease. With all the reservations necessary in assessing neuroticism in such a different culture, all the evidence I have is that this is the case. Psychotic illness, mainly schizophrenia, is still prevalent. Viewed by the Chinese as a manifestation of a conflict between the personal egotism of a capitalist society and communal responsibility of socialism, they hope to see even this illness reduce. In the meanwhile, psychiatric hospitals eschew E.C.T. and, where possible, the use of major tranquillisers. Treatment is an attempt to reintegrate the sufferer into their socialist society by maintaining close contact with work mates and local residents, reading together familiar literature (Mao Tse Tung's thoughts) and having a very high staff/patient ratio—occasionally even a 1:1 ratio.

There is no evidence that dissidents are pronounced psychiatrically disturbed. They are treated in the traditional Chinese fashion by persuasion and self-criticism with the new dimension of reform through physical labour added.

China, a third world country, has thus transformed its medical scene as no other third world country has—what relevance is this to us? We are faced in the West with illness which we neither have the resources nor, more importantly, the ability to treat. So like the Chinese only 25 years ago, we are faced with the necessity for a radical preventive programme if we wish to improve our nation's health. The Chinese method of mass involvement works, and works quickly, even in seemingly intractable disease like schistosomiasis. It depends upon a willingness to share knowledge and responsibility with non-professional people. In Great Britain there are many potential bare-foot doctors, the retired, the bored housewife, concerned workers and school children, to mention only four groups. The facts of prevention are simple and well known, but we have no home grown method of implementing that knowledge. Why, then, not create a network of locally based medical health workers, keep them integrated with their communities and attempt to build a participatory and caring health structure around them using our medical skills to guide and inform, not impose? We need a new Chinese type emphasis in medical education and a widening of the base from which students are selected. We should strive towards a higher level of involvement in and commitment to a preventive network programme, coupled with a democratisation of our health service so that many more ordinary people could become increasingly involved in health care. This would help the prospective network get off the ground. Most of us bemoan the lack of involvement in all areas of our life. In medicine we certainly have the need for a new approach, China's experience offers us a way even in spite of all our social differences, and given the will, we might even transform our country's health as the Chinese have theirs.

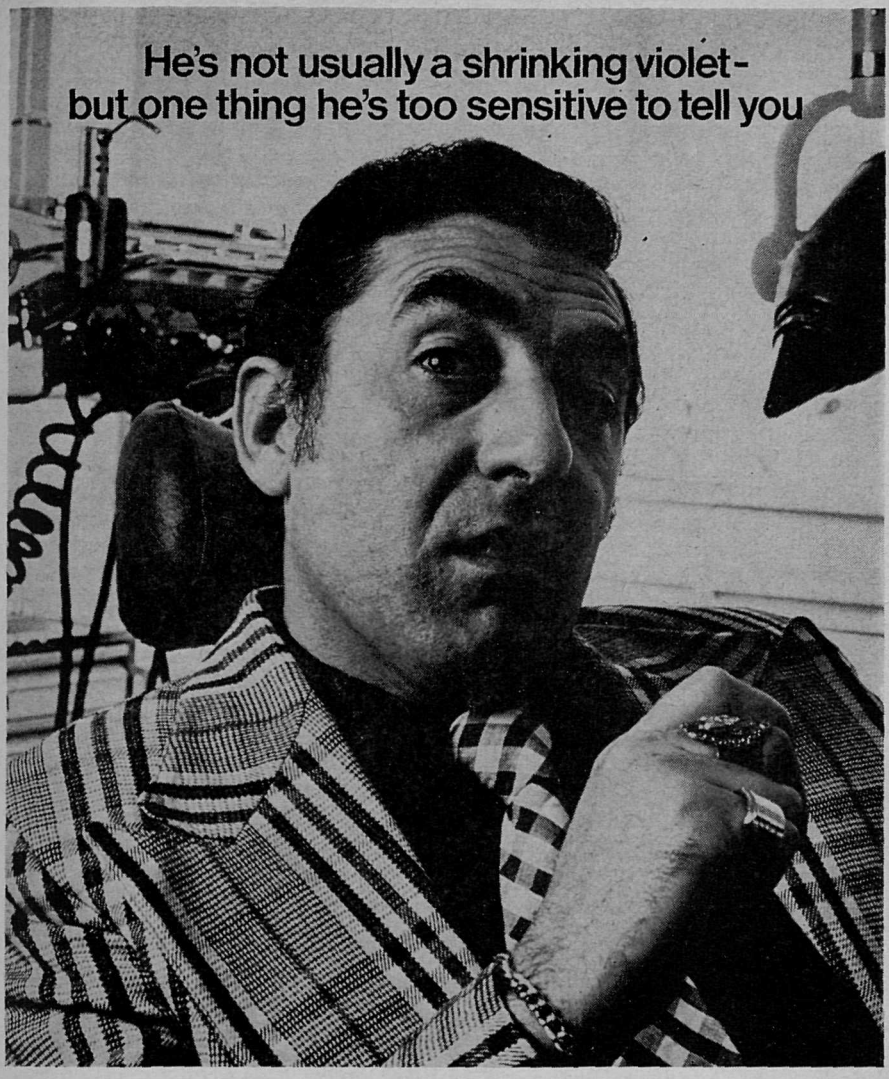
RHEUMATOLOGY IN THE COMMUNITY

The Second of four papers presented to the 4th annual meeting of G.P.s and Hospital Consultants of the Guy's Health District

by Dr. R. Grahame, Consultant Physician

1977 was designated World Rheumatism Year by the International League Against Rheumatism with the blessing of the World Health Organisation. 1978 has been earmarked by the British League Against Rheumatism as a year devoted to education in Rheumatology.

A recently published survey of 1,000 new presentations in a general practice in London has shown that rheumatological complaints constituted 10.6% of all cases (Billings and Mole, 1977). Yet many practising family doctors will have received little instruction in the management of rheumatic disorders in their undergraduate training and few will have had much in the way of postgraduate experience. Fortunately, the situation is changing. Nowadays most medical schools provide exposure to Rheumatology in the curriculum and increasing numbers of junior hospital posts, both at the House Officer and Senior House Officer levels, contain a commitment to Rheumatology either on a part-time or a rotational basis. Therefore, General Practitioners of the future can look forward to a better start than most of their predecessors. It is towards this latter group of doctors that the present scheme is directed.



It's about his sensitive teeth. He doesn't complain because he thinks that nothing can be done to help.

When you've diagnosed his hypersensitivity, why not tell him about Sensodyne toothpaste and the Sensodyne Gentle toothbrush – the complete home treatment for sensitive teeth and gums.

In no time at all he could be eating Neapolitan ice-cream and drinking scalding coffee like he used to do.

More important, he could be cleaning his teeth properly again – and giving hypersensitivity the brush-off for good.

SENSODYNE

toothpaste and 'Gentle' toothbrush
complete home treatment for
sensitive teeth and gums.

Stafford-Miller Quality products for dental health. Professional supplies available through Claudius Ashe & Co. Ltd.,

In Billings and Mole's study it was shown that a large proportion of the conditions encountered were eminently capable of being adequately managed by the General Practitioner in the surgery or in the patient's home without the necessity of referring the patient to hospital (with all the delays that this may entail), given a modicum of additional expertise and facilities. The aim of the present scheme is to enable those G.P.s who express a wish to obtain such expertise to achieve it. The most fruitful areas appear to be the diagnosis and management of those rheumatological conditions commonly encountered in general practice, e.g. back pain, tennis elbow and painful shoulder; the proper use of physiotherapy and occupational therapy, both of which are available at Guy's to General Practitioners on open access; and practical instruction in local injection techniques which form an important part of the rheumatological armamentarium. Where this training programme differs from previous ones is in that it is intended that not only will the General Practitioner attend the Rheumatology Department in the Hospital but also visits will be made by the Rheumatologist to the surgery, where suitably selected patients can be seen and discussed. It is hoped that a Community Physiotherapist will also be in attendance to give advice on the role and limitations of physiotherapy in these conditions.

A pilot scheme was enacted by Dr. John Davies last year with a number of selected practices. The response was sufficiently encouraging for plans to go ahead to approach all General Practitioners working in the Guy's Health District. A postal questionnaire was duly sent and the response was unexpectedly good. Not only did 70% of doctors return the questionnaire (very unusual in postal surveys!), but 60% signified their interest in taking part in the scheme. With fifty-five eager General Practitioners scattered in twenty-nine practices throughout the District, the project will no doubt stretch the limited resources of manpower and time of the Rheumatology Department to the full. It is hoped however that the scheme will have commenced operation by the time this article appears in print. Even now, the idea seems to be catching on. The British League Against Rheumatism is setting up a number of similar schemes, based on our own in other parts of the country.

REFERENCES

Billings, R. A., Mole, K. F. (1977). "Rheumatology and General Practice—a Survey in World Rheumatism Year, 1977". *Journal of the Royal College of General Practitioners*, **27**, 721-725.

FILMS

The Moulin Rouge Complex sounds like something that you might develop, but it is, in fact, a West End cinema. It is currently offering its heavy breathing viewers "**I'm not feeling myself tonight**" or **"Up and coming"** or **"Draws"**, which is advertised as being the film "that makes Jaws look like a lovesick goldfish". Poor competition really for the British Rail spokesman, who announced last week that he reckoned that the train service between London and Luton could be vastly improved by having more trains stop at Luton. Or even for the actress on I.T.V.'s most boring American film repeat last night, who said unsmilingly that she had been to bed with several princes, but always woke up with frogs. Talking of which, there are several excellent French films on at the moment, of which

"Pardon mon affaire" (Curzon) and the **"Lacemaker"**, which I reviewed last issue (Academy 2) are but two. From the womb, or better the bowels, of the English-speaking film industry, not a single good film has emerged in the last two months (with the possible exception of **"Julia"**), and that is why I am being so facetious in my introduction. Our own British film industry is entirely crippled at the moment. We have incredible talent in this country in actors, writers, directors and technicians (all the special effects in **"Star Wars"** were done in this country). Yet the absurd Union rules (which are unpopular with their unemployed members), and poor return in capital in this country, mean that no one in his right mind would consider making a film over here, and it is doubtful whether Sir Harold Wilson's proposed system of subsidies will do anything to help the basic defect.

That's the bad news. The good news is that there are a lot of last year's films still about, which are worth going to see on nights when the Guy's film society is not showing one of its excellent selection. **"The Pink Panther strikes again"** and **"The return of the Pink Panther"** (Scene 2, Leicester Square) are both guaranteed to make you laugh. In the first film the bungling Inspector Clouseau (Peter Sellers) sets off to catch the Pink Panther, in the second he sets off to catch his demented ex-chief inspector, who has threatened to blow up the world in his relentless quest to "kill Clouseau". Typical of the world's contempt for the poor Inspector Clouseau is the scene when he enters a hotel lobby, which has a vicious little dog sitting by the reception desk. "Does your dog bite?" asks the inspector, "No" replies the senile receptionist. Inevitably the inspector is bitten by the dog and turns on the receptionist, "But you said that your dog didn't bite", who replies "Ah, but that is not **my** dog!". Another double bill that will educate and amuse those who haven't yet saturated themselves in Monty Pythonism is **"Monty Python and the Holy Grail"** with **"And now for something completely different"** (Gala Royal, Marble Arch).

Butter has become a household name since **"Last Tango in Paris"** (Times Centa, Baker Street) first hit the screen. Nevertheless in spite of lurid 57 varieties of lovemaking, it is quite a serious film about a relationship between a bored and stunning French mademoiselle and an American, whose knickers have been thoroughly twisted by his wife's suicide. If you're feeling in rather the same way yourself, it's quite a good film to go and see is **"One flew over the cuckoo's nest"** (Filmcenta, Charing Cross Road), which everyone has been talking about, and which together with **"Family Life"** should be compulsory viewing on the Psychiatric firm.

Finally, a film worth going a long way to see is the Australian film **"Caddie"** (Odeon, Barnet), made by the same director as that of the rather different film **"Picnic at Hanging Rock"**. It is a very sensitive film about the adventures of an attractive middle aged woman, who decides to leave home with her two young children, after her husband starts having an affair with her best friend. Not such a terrible thing to happen in the seventies, but this is Australia during the depression of the thirties, where having the right sort of friends means not starving. It is exactly the kind of film, which would probably have been over-indulgent had it been in French, that our own British film industry ought to be producing.

Michael Dixon.

PHYSIOTHERAPY

Parkinson's Hassle

When the staffing level of the Guy's physiotherapy department was agreed, it was against the background of a service element provided by the students in the School, as they worked on wards and in out-patients to gain their clinical experience. At that time, the students hardly ever left the Guy's confines, and so the physiotherapy establishment of the other hospitals now in the District was not affected in quite the same way. Most if not all of each student's Minimum of 1,500 hours of clinical experience demanded by the curriculum was obtained at Guy's.

That 1,500 hours was spread over 3 years, so one could calculate that an average of 500 hours per year per student would be contributed by the School to patient-treatments, approximately 60,000 in total. It would be fair to assume that, since the students would range from the almost-qualified to the hardly-started, the average of their work would be not only less effective but also more slowly performed than by qualified and experienced therapists, and a generous estimate might be that three students would be equivalent to one member of staff.

Each member of staff, if we exclude overtime, is expected to work a 36 hour week for about 46 weeks a year, allowing for odd Bank and other statutory holidays, thus her annual "hourage" will be about 1,650 hours. What would be the establishment increase needed to equate with a student-less situation at Guy's? Rather more than 12 extra staff, a fifty per cent increase, which sounds about right when one considers comparable teaching hospitals in London without a physiotherapy school.

This, it should hastily be made clear, is not a public declaration of intent to remove students from the clinical situation. However, let us look at the present position. . . . Each student now is required to have 1,000 hours clinical experience, one-third less than before, and this is to include clinical teaching, which implies that a "student-labour" attitude is inappropriate and that the "service-element" concept is anachronistic.

But even if we ignore the philosophical niceties of the difference between the old "training" and the new "education",we still have to accept that physiotherapy students spend one-third less time treating patients than did their elder sisters when the staff-establishments were worked out. Furthermore, they nowadays go out to New Cross, St. Olave's and other hospitals outside our District, so the actual number working at Guy's has markedly fallen.

Are the other hospitals in consequence over-staffed, since they have students now where once there were none? Is the nature, scope and volume of their work the same as it was in those pre-Guy's Group days? Most emphatically not, and that is one reason why the students are there today. Had there been no students their staffing must have been increased.

What is to be the solution? At present, the staff and the students are working flat-out, and still demands are being made for further extension of the physiotherapy service. If we overlook the course-changes and the students' going out to treat patients, and confine ourselves to the reduced clinical hours in their curriculum, we should have four more qualified physiotherapists on the Guy's establishment. In terms of total expenditure, this would be a trifle, but as Parkinson warns us, the hassle to bring it about would be in inverse proportion.

Ronald J. Cooper.

NURSING

The Illiterate Nurses

At a recent nursing seminar the statement was made that members of the profession are politically illiterate: they do not read, cannot write and rarely speak.

These comments seem calculated to cause dissent, and doubtless there are many nurses who will express their disagreement. However, it is surely worthwhile considering the statement and the truth contained therein.

The traditional image of a nurse is that of a person who not only serves but is subservient. She is in the eyes of many, not least her own, so engrossed in the needs of her patients that she cannot and will not give thought to matters which do not immediately concern her, or are thought liable to destroy her professional image.

Politics is not a topic which nurses usually wish to discuss, or a "game" in which they have any desire to participate. Unfortunately though, the events of recent years have so altered the role not only of the nurse, but of women in society, that whether she desires it or not, she must of necessity now be willing to take her part.

Members of the profession have, on the whole, always been content to allow others to speak for them. This has been true to such an extent that direct appeals have frequently been made, particularly to the doctors, asking them to lend support to a cause. This assistance has of course proved very useful at times, but has also meant that the opinions of nurses have often been totally ignored. Since the recent changes in the profession, the doctors are less willing to provide a shield, which means that nurses must now fight their own battles. The doctors are somewhat distressed by the fact that they have lost their handmaidens. The result of this has been that the nurses have been left unprepared to accept their new responsibilities. They are not skilled at stating and arguing a case, and do therefore lose the respect of others in multidisciplinary forums.

The second part of the original statement is also true. Any nurse who is responsible for editing or co-ordinating the literary efforts of any of her colleagues will bear witness to the fact that they cannot write, as will any tutor who has the misfortune to undertake the marking of test papers. Whether this is simple inability to use plain English, or total lack of original thought, is not clear, but the facts demonstrate a situation which gives nurses the image of being both illiterate and unintelligent.

Nurse training does not, unfortunately, take any steps to rectify the sad state of affairs. Students are told facts, but are not encouraged to search for knowledge. They are also given little opportunity for discussion. Furthermore, the recent alteration to the examination system means that there is even less incentive to express oneself in writing, a fact which is demonstrated by the quality of the articles in the nursing journals, many of which in any case are not written by members of the profession.

It is surely time that nurses made an effort to improve their image. Until they can prove that they are capable of holding their places as members of multidisciplinary teams, full recognition will not be given to them. Until this happens, they cannot expect to be regarded as professional people.

Pam Jeffries.

RADIOGRAPHY

New Coats For Old

This month I am going to relate a piece of radiographic folk-lore. Nobody knows how old this tale is but it was being told as an ancient legend when I first came to work on the Guy's staff in 1971. It had been decreed by the powers that be that, at long last, the radiographers were going to have new white coats, a more modern and functional creation with professional elegance!

In 1971 the first prototype was wheeled from the committee rooms and submitted for staff approval. That particular design was rejected and the committees and the meetings started all over again to try and find a more acceptable one.

Time marches on and so reluctantly do the radiographic staff in coats decimated by some ghostly vandal who wantonly mutilates buttonholes, sleeves, pockets and hems leaving tattered relics. Those coats not mutilated were often innocently surrendered by the staff to a more terrifying and mysterious fate—the Bermuda Triangle of Guy's! This eighth wonder of the world exists between the department dirty laundry bin, Guy's laundry service and the clean coat cupboard. On entry no-one can predict which of the coats will ever return. It must be said that most of the coats entering the triangle pass through it with no mishap and return from their hazardous journey quite safely; but some, mostly newly issued coats on their maiden journey, are never seen again. All that is left to wonder over this mystery is the staff in a state of shock and with an overpowering sense of loss.

The summer of 1976 saw a new design unveiled for the staff's comment and approval. Despite some derogatory comments from certain members of the staff, the general concensus was that it was best to accept anything that was offered rather than run the risk of having to wait another five years for the unveiling of a new design. So orders were taken for staff requirements of the new coats—short or long-sleeved dresses or tunic tops. The new uniforms were to be issued to coincide with the big move to the new department in the Tower. November 1976 saw the move take place and much to everyone's surprise no new coats come with it. So we wait again!

In the summer of 1977 notification was received that the new coats had arrived and all that was needed was the names of the staff for distribution purposes and the desired lengths of their uniforms. So it was that the staff dutifully trooped to the linen room for the ceremonial measuring thinking it surely couldn't be long before they got their new coats. Foolish girls!

Christmas came and went, the New Year arrived, but still no new coats. More telephone calls were required. It seemed that the coats were not after all being named and hemmed, but being reserved for issue to new members of staff. After full explanation of the situation the answer was simple, all that was needed was the complete dismissal of the whole radiographic staff on one day and its complete re-employment the next with the ensuing issue of the new white coats. However there are some of us who are not too confident on the re-employment phase of this solution, and so we wait.

Jill Guest.

BOOK REVIEWS

"Endodontics" 2nd Edition, by E. Nicholls. Pp. 360. Price £15.00. Published by John Wright, Bristol.

The first edition of this book, published ten years ago, rapidly became a standard text on Endodontics in this country and has been out of print for some time. This new edition contains many changes and there is also a considerable increase in the text which reflect the changes that have occurred in the subject over the past decade. Considerable attention is devoted to the maintenance of pulpal vitality by direct and indirect pulp capping and to the relationship between pulpal and periodontal disease. Root canal treatment on molar teeth is now regarded as commonplace and the illustrations of radiographs in the sections on this subject draw attention to the author's great skill as an endodontist particularly those showing retrograde root fillings in molars.

He has also included a section on the use of endodontic stabilisers and on the treatment of immature pulpless teeth. The reviewer regrets to see the work "apexification" rapidly gaining acceptance as a description for this latter procedure since the sole object of the procedure is to allow the root apex to complete its formation and it seems unnecessary to use a clumsy new word.

Many of the chapters have been completely rewritten and the bibliography at the end of each chapter has been greatly enlarged. The book is profusely illustrated throughout. Unfortunately radiographs are extremely difficult to reproduce and some of the illustrations of these fall short of the otherwise high standard of the illustrations.

This is an excellent book aimed at both undergraduates and general practitioners. It is written in a pleasing yet authoritative style and it must be recommended as an essential part of the library of anyone interested in endodontics.

The price compares very favourably with American texts covering a similar field but Nicholls' book has the advantage that he includes many more references than most other texts.

Why did the publisher choose a bright yellow colour (which shows every mark) for the covers and omitted to supply a dust cover?

A. H. R. ROWE.

"Neurology for Physiotherapists", 2nd edition, by Joan E. Cash. Pp. 495. Price £5.95 (Hard cover version £7.95). Published by Faber and Faber.

When this book was first published in 1974, I welcomed it in the *Gazette* as a useful addition to the sparse collection of physiotherapy text-books, despite its weaknesses. Now, three years later and three pounds more expensive, the second edition appears with those chapters which were weakest either wholly rewritten or extensively revised, and with an increase to sixteen in Miss Cash's team of contributors, ten of them newcomers.

The first third of the book is unchanged, and consists of a review of the basic anatomy and physiology of the nervous system and a section on assessment and general principles of treatment which will continue to provide student physiotherapists with a sound foundation on which to base their treatments—and their answers to examination questions.

Other Chapters—on head injuries, lesions of the cord and peripheral nerves, and on psychiatric conditions—are unchanged, and there are minor changes in the chapter on spina bifida.

Bigger, and better, alterations are seen in the revised sections on multiple sclerosis and parkinsonism, but the best changes are in the sections on cerebral palsy, which I had in the earlier edition regarded as brief, didactic and unhelpful, on hemiplegia which is incomparably better, and on polyneuropathies which is perhaps still a bit of a rag-bag but is nevertheless a great improvement on its predecessor.

The first edition's chapter on geriatrics has sensibly been removed, and replaced by two chapters on community care and physiotherapy which are full of good sense, and down-to-earth practicality. The section on applied psychology which replaces its first edition counterpart, gains by having been written by someone who knows physiotherapy at first hand, and is the more pointed for it.

There are new plates and many new figures (beautifully drawn by Audrey Besterman), and the whole book has gained greatly by the addition of its new chapters and by the rewriting of some of the old. It will be an essential inclusion in the libraries of both students and staff of physiotherapy schools and departments, and could well be useful, as its publishers hope, to other paramedical groups.

R. J. C.

"A Guide to Dental Radiography" by Rita A. Mason. Pp. 136. Price £5.00. Published by John Wright, Bristol.

This book covers the field of radiography of the teeth and jaws including X-ray hazards, generation and properties of X-rays, films, processing and film faults. Intra-oral and extra-oral techniques are fully described with much sensible advice.

In intra-oral radiography, the angles for various regions in standard periapical radiography seem to me to be overstressed. The important advice in the standard, bisecting angle technique is to observe the lie of the film and the plane of the tooth and position the tube accordingly. The angles given for different regions can be a guide but must be only approximate. Paralleling or long-cone technique is quite well described and also occlusal views through the vertex occlusal positioning is not correct. The vertex is at the front end of the sagittal suture where it joins the coronal suture and the central ray goes through this point. Centring is shown further forward in Figs. 85b and 86b and the frontal bone is projected over the front teeth. It should fall anterior to them.

Fourteen different positionings are described in the oblique lateral technique. The variations between several of them with the angles given are so slight that I am doubtful if Mrs. Mason herself would always achieve just what is implied with all the disparity there is between one patient's jaws and another's. In most general radiography the patient can be held straight and specific angulations give consistent results. Not so in the oblique jaw views.

Under "Postero-anterior Techniques", the first projection is called "Postero-anterior". What is described then is generally called a "reversed Towne's projection". Towne's projection is described later although this view is primarily for the occipital bone and is less often used in dental radiography because the jaws tend to be nearer the film with the reversed positioning.

The next projection, "Postero-anterior with Mouth Open", is claimed to give "an excellent view of the temporo-mandibular joints". What is shown is a good view of the condyles and their necks but the opposing sides of the joints, the glenoid fossae, are not shown at all. Most oral surgeons are quite satisfied to see the condyles but it is important to be clear what is shown by a projection as well as what is required. This view (the open mouth reversed Towne's) can also show the zygomatic arches but to show them and the condyles and necks well, it is important for the radiographer to make a paler film and not to penetrate to show the fronts of the jaws for these regions are obscured by the cervical spine anyway.

The description of the orbiting panoramic machines is rather too hopeful. Mrs. Mason calls the system "rotational tomography" and this is far more of a misnomer than that of bimolar projection on page 99. The system is excellent as she says for the rami, the condyles (if the mouth is open or the jaw protruded) and the lower molars but can be deplorable in the anterior region of either jaw. The result would be more consistent here if all jaws were the same shape but they are not. The great difficulty is to move the shadows of the teeth across a narrow slit at the same speed as the film is moved behind the slit. Standard tomography is child's play compared and the wanted shadows are sharp. Even true rotational tomography can produce sharp shadows reliably although I have less experience of rotational systems than of linear tomography.

I am disappointed that Mrs. Mason did not describe the static panoramic machine. This gives very good detail at the front of both jaws including the full depth of the mandible although the molar regions are less readily shown. It provides a valuable complement to the orbiting panoramic film with a low radiation exposure.

Many of the interpretations are at least suspect. Possibly in the original films there was something which could be interpreted as stated but on several occasions this has been lost in reproduction, e.g. Figs. 99b and 122a. Much is lost in others. Many films are too dark and most are too contrasty. This is a great difficulty in radiograph reproduction. Each stage of photography and printing tends to increase contrast and a good radiograph has a high range of contrast to start with. I find it advisable to select a somewhat paler and relatively flat film to start with in order not to lose the pertinent details. Beggars cannot always be choosers of course but for radiography illustration a range of normals is available to select from.

It is very important for the dental student both under- and post-graduate to have a clear idea of the commonly used extra-oral projections as well as practical experience of radiography with a dental unit. This book is written by a radiographer and so stresses a straight patient and fixed angles. Some adaptation to the off centred patient is more regularly needed in dental radiography than in general radiography and this comes of course with experience. The book is a very useful and thought provoking guide for the dental student and practioner and has all the background information he needs.

FRANK INGRAM.

"Immunology. An Outline for Students of Medicine and Biology", 8th edition, by D. M. Weir. Pp. 206. Price £2.50. Published by Churchill Livingstone.

Immunology is one of those subjects capable of striking sheer terror in the mind of the student or qualified doctor alike. So, to overcome the ostrich in the sand reaction, why not read a small book? Dr. Weir, in his latest edition, condenses the essence of modern immunology into 200 small pages which, at £2.50, should be within everyone's pocket. He takes a definite medical rather than biochemical approach to the subject, which makes the major distinction from the rival new edition "Essential Immunology" by I. M. Roitt (Blackwell, about 300 pages, £3.75). This, however, makes more difference to the organisation than to the actual content of the two books. The fuller treatment of immunity in infectious disease, specially of the ways that organisms avoid the defences is most interesting, and will please those who believe that the importance of immunology extends beyond the spleens of laboratory mice. Haematology is also given more attention. Weir's preface expresses concern that simplification has not sacrificed accuracy for clarity. I could detect no significant factual errors, and brevity certainly has been achieved.

The style of writing and presentation are a shade duller than Roitts, but it is indeed always clear, with important facts emphasised in heavy type. The diagrams are not quite as profuse and perhaps too diagrammatic, antibody molecules appear as large as white cells, and IgM molecules look like something from the "Sky at Night"! These differences no doubt depend partly on the lower price of Weir's book.

For medical students, it might possibly be the easier book to use in revision, as it is more of a conventional concise text book. If an academic approach is acceptable, Roitt's is a more attractive book.

ROBIN POSTON.

"Radiographic Techniques Related to Pathology", 2nd edition, by Margaret Clifford and Ann Drummond. Pp. 70. Price £2.00. Published by John Wright, Bristol.

This slim volume sets itself the task of providing advice for the radiographer in a department where full-time medical supervision is not available. The idea is a good one and it is one which can be only partly achieved by the written word. Even making allowance for this, I cannot say that the book under review fulfills all the possibilities.

The authors have tried to explain the sort of medical terms that are likely to appear on request forms and after a short note on each condition there is an indication of the radiographic views that are likely to be required in the management of the patient. The first part is generally very good, and I would recommend the book to the newly-qualified radiographer or student radiographer for this reason alone. The question of choosing the appropriate film for each condition, however, is a question of the preference of the radiologist in charge and is therefore difficult to formalise in book form. Furthermore, the introduction of ultrasound, nuclear medicine and computerised tomography has meant that much plain film diagnosis has now been superseded. Even in departments where patients require interhospital referral for these facilities I think that most radiologists would regard many of the films recommended here as unnecessary padding in the reporting file. Instead, in this second edition I think the authors would have done well to enlarge their definition of clinical terms and eponyms, perhaps giving a list of the possible findings in pathological terms (soft tissue calcification, masses, bony destruction, etc.) so that the radiographer could use his or her experience and training to choose suitable films. Apart from this, the radiographer who requires a good "phrase book" to decipher the medical expression in common clinical practice will find that this pocket volume is well worth its modest cost.

STEPHEN GOLDING.

CORRESPONDENCE

Open letter to the gods

Dear Bacchus,

I enjoyed your article in the Christmas *Gazette*. You twice refer to the Leathersellers Arms when I think you mean The Leather Exchange Tavern. I also understand Becky's has re-opened.

I wonder whether you could do another short article (editor permitting) on food. As a newcomer to Guy's I note a lack of middle-range eating outside: there are snack bars and two or 3 wine bars you mention but ? Chinese, Indian, Kebab, etc.

Yours sincerely,
P. J. HOWATT.

Department of Chemical Pathology,
Guy's Hospital,
London, SE1 9RT.

H.O.P. Bar

Madam,

Referring to Mr. Robinson's letter in last month's issue the Rugby Club would like to express its full confidence in the efforts of Eric and Joyce Dann and all the ground staff at H.O.P. The friendly atmosphere which now exists at the Ground is a direct product of their labour, they do a difficult job well and combine excellent preparation of the sports grounds and changing facilities with catering of the highest standard—this despite the problem of a sporadic trade. As for opening hours, Mr. Robinson has got his facts wrong since these are a matter for consultation and agreement between the Medical School and Mr. Dann. It is also Eric's policy to give good notice of the bar closing, and to ask individually if anyone would like another drink before closing. He is then content to let his customers finish in their own time, not something usually found in Clubs, in all a very fair arrangement.

Yours faithfully,

G. FRANCIS,

Captain of Guy's R.F.C. on behalf of the Rugby Club Committee.

What is wrong with the N.H.S.

Madam,

The view from the bottom rung of Lord Moran's ladder is, possibly understandably, very different from that expressed so eloquently by David Armstrong and the other authorities at more elevated levels.

As one who has been involved with the N.H.S. since its inception, I should like to make the naïve suggestion that an understanding, if not a solution of the problems may well start with the patient and his or her illness or, alternatively, the illness to which he or she may, in the future, be susceptible.

As I see it (from the bottom rung) the most important and fundamental constituent in medical practice is the relationship between patient and doctor. The relationship to which I refer is based on mutual confidence, it is the concern solely of the patient and his or her doctor and it is something which develops in its own good time. Only in very rare circumstances indeed is it an instantaneous occurrence. However, it is possible for this relationship to be transferred, as it were by proxy, to other doctors, to nurses, to physiotherapists and so on throughout the complex hierarchy which constitutes the N.H.S. Ultimately though, it comes back to the rapport between patient and doctor at the bedside or in the consulting room. By its very nature this relationship cannot be bought or sold and, above all, it cannot be manipulated by a third party however well intentioned they may be. It most certainly is not established at the moment a doctor signs his acceptance of a patient on his N.H.S. list.

At this point we might return to David Armstrong's very last sentence—"Health, as a part of politics, must become the art of the possible." I should like to rephrase it as follows—"Health, to become the art of the possible, must be made as little a part of politics as possible."

In other words, to put right what I see as "Wrong with the N.H.S." we should start by looking at what happens when a patient wakes up at home in the middle of the night, cannot get his breath and telephones for a doctor. No Act of Parliament can ensure that his telephone call summons swiftly to his bedside somebody whom he knows and trusts and in whom he has confidence to deal with his distress. But would that be so much to ask? To achieve this is not an unattainable goal, it would cost comparatively very little and it would be the greatest possible step in putting the N.H.S. back on the right course.

Broomden, Ticehurst, Wadhurst, E. Sussex, TN5 7LP.

Yours faithfully,

B. A. TUDGAY.

A Broader View

Madam,

The sociologists have interpreted the N.H.S. in their various ways; the point, however, is to change it.

David Armstrong is right to point out that health problems are essentially political problems and that the question of "What is wrong with the N.H.S?" is subsumed by the question of "What is health?", but the fundamental question must be "Why do we have a society which promotes ill-health, and what can we do to change it?"

Whilst it remains profitable to produce "junk food", carcinogenic chemicals, cigarettes and leaded petrol, we will suffer the consequences, despite repeated and half-hearted appeals to the individual to modify his pattern of consumption. The hope for the future must lie in challenging the economic order which makes it easier and more lucrative to produce illness rather than health.

East Wing, Guy's Hospital, SE1 9RT.

Yours faithfully,

STEPHEN WOOD.

The Preclinical Biochemistry Course

Madam,

I was interested to note a certain variance in the views expressed by Professor Diplock in his recent *Gazette* interview compared with those we have learned to expect from other teachers of Biochemistry.

Although not a trained clinician, Professor Diplock obviously appreciates the main difficulty encountered by medical students within the preclinical Biochemistry course, that is, its overall relevance to clinical medicine/practice. As a staunch advocate of the introduction of more clinical relevance into the course I can only enthuse over his ideas. However, I remain *cautiously* optimistic, since experience shows that what is *said* is not necessarily *done*. Whilst it would be somewhat naïve to expect the "new brush to sweep clean", hopefully, what he has stated will translate into a discernable change in the teaching from his department. His first priority is the present lecture course, overladen with irrelevant metabolic pathways and formulae, of no use to the future practising doctor and in dire need of "pruning". There still remain considerable overlaps with the Physiology course, especially in the areas of digestion, absorption of food, respiration and acid-base balance. Other subjects such as calcium/phosphorus metabolism and the immune system are dealt with more succinctly by the Clinical Chemistry and Pathology departments, at the same time incorporating relevant clinical details. These examples, amongst others, should amply illustrate my point of view.

In addition, I strongly feel that he could be committing a grave error if he did not seriously consider the present and most unsatisfactory format of the practicals. Student motivation towards these has always been poor, largely engendered by the unattractive subject matter. Is it really necessary, for example, for a doctor in training to be able to titrate amino acids, or learn about centrifugation techniques? I believe the answer is NO! The practical course could be reduced by at least 50% without undue disruption to the course overall, thus creating approximately 30 hours of useful curriculum time. Not only should the number and length of the practicals be reduced, but they should be complemented by a change in content, integrating clinical specialities such as the Clinical Chemistry department, as is already done with practicals in Term V. These admittedly radical changes should not alter the students' awareness of the underlying biochemical concepts and processes applicable to common problems in clinical practice.

My personal view is that critical evaluation and reorganisation is needed at this moment in time concerning the Biochemistry course *in toto*, although I agree with Professor Diplock's comment regarding the step by step implementation of such reorganisation within the B.M.S. course as a whole. I hope his own experiences at the Royal Free will enable him to pinpoint the major problem areas.

Yours faithfully,

W. SCOTT-SMITH.

c/o Boland House,
Guy's Hospital, SE1 9RT.

The Threat of Fascism

Madam,

Now that the *Gazette* is entering the pre-election political arena (Passim, No. 2278) may I, whilst applauding your plea for common sense in combating the current hysterical campaign against the right-wing, point out for the sake of accuracy that Mr. John Kingsley Read is not a member of the National Front.

His welcome departure from that party about two years ago was not entirely unconnected with his attitudes and behaviour, an excellent example of which we have recently witnessed.

By the way, what is a Fascist? The best definition I have recently heard is that he is someone who doesn't agree with oneself. I have certainly seen it applied to proponents of all ideologies, from Rhodesia through Uganda, Israel and Russia.

Yours faithfully,

CLIVE BROOKS.

1 Esplanade,
Rochester,
Kent, ME1 1QG.

Editor's Note.—The author of last month's Passim, Mr. A. P. J. Pini, replies: The Passim of last month stated, "The John Kingsley Read trial aroused a great deal of ballyhoo concerning the right to hold opinions and speak freely and of the dangers of racism and the National Front." This does not imply that John Kingsley Read is, or has been, or is even ever likely to be a member of the National Front or any other party, but perhaps this is a fascist reply!

A. P. J. P.

Guy's Hospital Dental Society Dinner

Madam,

Having attended almost all the Dinners since qualifying in 1951 and found them such enjoyable and relaxed affairs, I am very disappointed to learn that it has been decided to alter their very nature. They are to become Dinner/Balls.

Dinner-dances and the like can be attended and enjoyed at any time as they occur—be they related to one's clubs or whatever. However, the Dental Society's Dinner was something of its own and rather special. At least, it was to me. Whoever decided to make the alteration I feel has somewhat missed the point of the function as it was.

A smaller point, perhaps, but an important one to those who have to travel long distances to come to these Dinners, is that of the additional expense entailed —two rail fares, two hotel charges and the like. There are alternatives of course. One need not come at all or one leaves one's wife at home and attends alone, although I don't relish the idea of acting out the wallflower at my advancing years!

Should a campaign ever develop on this issue, I should like it recorded that I should be available as a banner-carrying picket to "Bring Back the Dental Society Dinner—Old Style".

Yourth faithfully,

NORMAN MAYSON,
L.D.S., R.C.S.Eng., Guy's 1946-1951.

"Mayfield",
Middleton Avenue,
Ilkley, West Yorkshire
LS29 0AH

SPORT

SPORTS COMMENTARY

After the depressing item in last month's sports report, I thought I would try to be more cheerful. However disappointing Brian Bore's predictions may have been, things have actually proved more dismal still. The Rugby 1st XV have been knocked out of the hospitals cup by the London Hospital, after a tough fight. That same hospital also knocked the 1st soccer team out of their cup. The latter game had been rearranged to a Sunday morning at H.O.P. by the London, who also provided their own "qualified" referee. This chap just happened to be their captain and he surprised even his own team by generously awarding them a free penalty after five minutes of play. London's confidence thus boosted, they were three up in an hour. Even a spirited revival bringing two comeback goals could not prevent what was a very disappointing loss. I know one or two Guy's sportsmen who wish that the Middlesex Hospital arsonist had picked a different hospital for his fiery antics! However, the 2nd soccer team has reached the U.H. cup final for the second season running after beating Charing Cross 4—3 after extra time. I would like to wish Keith Underwood and his Hole in the Wall team every success in the final.

The weather has not been condusive to good sport in recent weeks, several games taking place in blizzards and many being called off. This will lead to the usual frustrations among Guy's sportsmen. So all you who are bored on Saturdays or whose pent up aggressions are getting you down, don't beat your girlfriend or damage any property but take up jogging.

Jogging is 'in' in America, so it must be a good form of taking daily exercise. Having swept across the U.S.A. the demon beer-bellied jogger can now be seen on England's hallowed shores. The Sunday Times has taken up the jogging cause, and even if you don't believe all you read in the B.M.J. surely you must trust this celebrated paper. The Health Education Council has recently launched a million pound advertising campaign to encourage those slack among us to exercise. Their advertisement includes questions to fatties such as—*What makes your pulse race more—Miss World or running after a bus?* Answer—running after Miss World!

It is with the backing of these two great institutions that I recommend to all you who are not getting enough exercise to jog as an alternative. For those new to the sport may I suggest a course. Start at Wolfson House and run round the back over Tower Bridge and return over London Bridge, round the edge of Guy's back to Wolfson House. Variations may be added to suit your personal taste. The skilled soccer star or hockey player may dribble his ball all the way trying not to lose it in the Thames; the Rugby star may take his pack and toss a ball between them. The nifty threequarter should come back over London Bridge in the rush hour and side step the commuters, whilst the athlete should reckon to complete the jog in twelve minutes.

Lastly here are some do's and don'ts for this regime. Try to jog at least once a week. Go in shorts as they make you look more active, and you shouldn't be able to carry money in them as this might tempt you into a pub if you get thirsty. No stops for a quick smoke are allowed and no shopping should be done. If you start shopping in short trousers, the Southwark locals will complain—especially if you have hairy legs. For the cynic let me offer one more advantage of this illustrious sport. Although it is not possible to persuade many ladies to play Rugby, you will find they adore to be asked out running. For all leg men this should be better than taking your lady to the pictures and will also help her to get fit. To all I wish you good jogging, and I should welcome correspondence suggesting routes and other jogging diversions.

Happy March,

J. J. EARNSHAW.

HOCKEY

Hospital Cup, 22/1/78

St. Mary's Hospital, 2 Guy's, 5

This was a very determined performance from Guy's, particularly after our display the day before. As usual we started slowly and after an opening flourish by Mary's, Guy's had a few chances. The defence then left the Mary's right winger free and he scored a good breakaway goal. Ten minutes later a defensive error at a short corner gave them their second goal. Finally Guy's got it together and with great determination from the half backs and insides we forced a few short corners. At the third or fourth a good hand stop produced a rocket shot from Rick Plowman and the deficit was reduced. Just before half time after many good attacks, particularly down the right with Julian Hart and Garth Saward playing well, a ball from the right caused a goalmouth scramble and Duncan Jones scored a lucky wide-angle goal. At half time we really believed we could win and within five minutes we went ahead with Rick Plowman scoring a good goal. The effort of the whole team now improved 100% with John Wilde and Peter Rowley running continually. The defence was very solid with Peter Holmes, Peter Sanders and Simon Cunnington tying everything up. For once John Pascoe got cold. With the constant pressure a goal was inevitable and the fourth was scored with a penalty from Pete Sanders. Ten minutes later Rick completed his hat-trick. The game ended with Guy's still attacking. This really was an excellent result with the whole team putting a hundred per cent into the game. Let's keep it up. Thanks to Mike Craigen for umpiring. Team: J. Pascoe, P. Holmes, S. Cunnington, G. Saward, S. Gulami, P. Sanders, J. Hart, J. Wilde, R. Plowman, D. Jones, P. Rowley.

RUGBY

Guy's 12 pts. Old Millhillians 6 pts.

7/1/78 at Headstone Lane

A good win for Guy's even though the whole team looked a bit sluggish after the Christmas break. Guy's began the game with twelve men, due to late arrivals but found their feet when the full complement of players was restored. The opposing scrum-half, after a few dangerous breaks did Guy's a favour by getting sent off for punching John Brazier. Millhillians managed two penalty goals in the first half while Hughes grabbed a try for Guy's converting himself.

The second half saw Guy's dominating play but could not score until Wilkinson followed up a chip ahead by Emery and won the race for the touch down. Soon after the conversion the opposition hooker went off with a cut forehead, but athough Guy's toyed with their six-man pack there were no more additions to the score.

Team: Wilkinson, Portelly, Emery, Hughes Francis, Broughton, Laws, Parry, Gibson, Hutchinson, Beard, Keevil, Brazier, Robertson, Hagan.

G.P.

HOSPITAL'S CUP 1st ROUND

Guy's 7 pts. Charing Cross 7 pts.

17/1/78 at Chislehurst

Replay: Guy's 16 pts. Charing Cross 0 pts.

24/1/78 at Chislehurst

Guy's Cup campaign finally got underway against Charing Cross, and resulted in a very close contest. In the first match Guy's began poorly and were soon a penalty down. Gibson managed to give Guy's the lead with an opportunist score from a line out near the Charing Cross line but Charing Cross came right back into the game in the second half with an unconverted try from their centre. Guy's survived by the skin of their teeth due to a Hughes penalty goal about five minutes from time.

Changes were made for the second game. Loxton taking his place in the second row, allowing Hagan to take up a roving No. 8 role and this proved decisive. The pack produced a liberal

second phase ball, and the backs some elusive running, Charing Cross were lucky to keep the score level at 0—0 in the first half. Guy's pressed harder in the second half and were rewarded by two penalty goals by Hughes, and two tries, one each to wingers Francis and Portelly, the first from a great ruck near the opposition line, the second after a break near to the try line by Laws. A confident, enthusiastic performance which could easily have resulted in a bigger win.

Team: Wilkinson, Portelly, Hughes, Emery, Francis, Broughton, Laws, Parry, Gibson, Hutchinson, Beard, Hagan, Brazier, Robertson, Palmer (plus Loxton).

G. P.

HOSPITALS' CUP 2nd ROUND

Guy's 3 pts. The London 9 pts.

31/1/78 at Chislehurst

This was a hard, fast, skilful match and the result was in doubt until the final whistle. The London's traditionally heavy pack began the match in control and some astute kicking from their half-backs kept Guy's pinned in defence. The London took the lead with a penalty after an offside decision against Guy's, and scored a converted try after running the ball from a ruck near the Guy's goal line. They had other opportunities but let them slip and Guy's turned, with wind and slope in their favour for the second half, 9—0 down.

The match now reversed completely with Guy's exerting all the pressure, half-chances came to both wingers but the golden opportunities went begging when The London managed to bury the ball in rucks near their line. Hughes kicked a penalty to put Guy's within one score of a draw but in 40 minutes of pressure Guy's just could not carve an opening for a try.

It was a great disappointment to go out of the Cup so early once again, especially as we had a particularly well balanced side this year. It was also disappointing to see the level of support for Guy's. If Charing Cross can produce about seventy supporters, surely Guy's can do better than a dozen?

Team: Wilkinson, Portelly, Hughes, Emery, Francis, Broughton, Laws, Parry, Gibson, Hutchinson, Beard, Loxton, Brazier, Palmer, Hagan.

G. P.

Guy's Present 37 pts. Guy's Past 6 pts.

5/2/78 at H.O.P.

The Past produced a strong side this year in a bid to level the series at 3—3 in this fixture and the heavy ground and slippery ball seemed to be in their favour. The Present side were denied possession early on but managed to kick a penalty through Hughes, and the Past replied with a try by Rooke converted by Owen after some diabolical penalty attempts by Novak.

This acted as a spur to the Present side who now took a running game to their opponents and ran away with the match. In the second half all the three quarters scored, Wilkinson sprinted from half way for his try and Hagan obviously relished his clash with full-back Owen before scoring his try. All this despite regular substitutions and re-substitutions by the Past seemingly in a vain attempt to get sixteen or seventeen players on the pitch at the same time. After the match Joyce again did us proud with the food and all revelled in the happy atmosphere of renewing old friendships and talking Rugby.

Teams—Present: Wilkinson, Portelly, Hughes, Emery, Francis, Broughton, Laws, Parry, Gibson, Neill, Keevil, Beard, Loxton, Palmer, Hagan.

Past: Owen, Novak. Moore, Campbell, D. G. Lewis, Thorburn, Crawford, Davies, Hey, Evans, Challacombe, Cockburn, Brown, Rooke, Neville. Subs.: C. Lewis, Kingdon, Baker.

G. P.

Angels 8 pts. Edenbridge 1st 7 pts.

14/1/78 at H.O.P.

It was an imperturbable young team which confidently assembled in the changing room at H.O.P. on Saturday, preparing themselves for victory. These were the Beers. In contrast, the Angels, four short at that point, were quaking, having just been told that it was Edenbridge's first team that some fool had matched them with. Apprehension developed into fearful resignation when, to make matters worse, it dawned on us that we were playing on The Big Pitch. As it turned out, the width of the pitch and its relative firmness helped the Angels' light pack and fast running, strong threequarter line.

Edenbridge kicked off and for a while the Angels were trapped in their '25', during which time the visitors went ahead by three points thanks to a drop goal by the fly half (at least we assume it was a drop goal—the referee asked their fly half and he said it was!). The Angels fought back, making ground progressively, until after the breakdown of a threequarter move and an untidy maul, Pete Birtles burst clear with the ball and successfully outstripped the opposition on the unenviable run half the length of the pitch to the line. Just before half

time, an unfairly large Edenbridge forward unsportingly used his weight to topple over for the try which left us 7—4 down.

The second half was one of frustration and tension with the much lighter Angels pack valiantly overcoming the handicap, thanks largely to the excellent hooking of Frank Mendel, to give the three-quarters an enviable amount of possession. It was not until we had survived our flyhalf's attempt to drop a goal over the corner flag, and Chris "slippery ball isn't it?" Jackson's aerial fumble on the line, that on one of the many occasions on which we had the chance to get the ball to the wings, it actually got there and Rod Robinson barged over for the winning try.

With five minutes left, defence of this one point lead became all-important and a suicidal last-ditch tackle by talented newcomer full back Mike Rees was paramount in ensuring that the Angels went in 8—7 victors.

Thanks must go to Guy's version of the Black and White Minstrels, Chris and Snowy, for their valuable vocal support!

SOCCER

Guy's 4, St. Thomas's 3

In a thrilling game in which both teams held the lead twice, Guy's were fortunate to lead at the end.

The visitors were in fine form and had not lost since being beaten in the autumn 8—2 by the Guy's team.

This time the game proved to be a very different story, with the visitors taking an early lead through a defensive error, and in fact the 1st half saw no further score in this take no prisoners battle.

After a harsh talk in the half time break, the Guy's team came out with more fight, and Mike Breeze scored from a rebound. But the visitors came back with power to go ahead again.

The game went from end to end as the teams struggled to get hold of the midfield. The equaliser came from a corner, which Andy Mitchell rose above the whole defense to head home.

Slowly Guy's took more control and inspite of more harsh tackling the 1st team went ahead via a double header effort from a long throw by Dave Abrahams. Minutes later the visitors got back into the game after a vicious drive and deflection that beat Nick Cowland although he had one of his finest games since joining the team.

The winner came late after intense Guy's pressure. A hard cross being headed home through the defense by Ian Wilson.

SIMON PERKINS.

U.H. CUP

Guy's 2, London Hospital 3

A most disappointing result for the 1st team, but few would agree that the result was totally fairly gained. Guy's were stunned as early as the first five minutes when the London were awarded a penalty for pushing in the box, a decision that stunned the London team as much as the Guy's side.

This incredible decision created a great deal of bad feeling amongst the teams. And the 1st half developed into a very hard battle, with little given away.

Guy's lost a second soft goal fifteen minutes into the game, but it was a measure of the team performance that this was completely against the run of play. The team was playing with a spirit not seen for a long time.

The defence of Harper, Mitchell, Maclachlan and Abraham looked a compact and effective unit. Dave Abraham's dealing of "Doug the thug" was in particular a joy to be seen.

The 2nd half saw the home team go a third goal down, and the day looked lost. But a superb fightback shook the London. Both goals came from set piece situations, the first by Paul Sheppard and the second by Dave Abrahams who had sneaked up to score powerfully from the corner kick. Inspite of incredible pressure and the visitors often being in trouble, Guy's could not find the goal that mattered. However, the London certainly knew they had been in a game. It is a shame that their attitude ruins these contests which have so much to offer United Hospital sport.

SIMON PERKINS.

THE CAMBRIDGE SOCCER CLUB TOUR

It was a cold wet night on the 27th January when two thirds of the soccer club met in the bar at 5. They left refreshed at 7.30 in the mini-bus. Upon reaching the M11, Tim Miller displaying northern intuition turned off for the A10, and immediately had an overheated engine which was replenished with liquid whilst the team relieved themselves. Dave Greenaway a native of these parts directed the team to a pub with a garage next door where the van was repaired and the team refreshed. Numerous further stops

were made for van and bladder relief, finally arriving 11.30 Friday night.

The rest of the team arrived via cars early the next afternoon to find the games were off due to waterlogged pitches. A conference in the Cambridge Arms was called and after much debate, and ale the day was saved when it was realised that Cambridge United were playing Chester!!!?!

For this key 3rd Division match the 4,000 crowd were stunned into silence by the chanting of the East Wing Boot Boys, Chester and Cambridge responded with a thrilling nil, nil draw. Billy had the match of a life time. John 'Flying' Rawcliffe caused the only crowd aggravation of the match when a Cambridge supporter attacked him. Still the delights of Cambridge were not over.

On hearing that the matches on Sunday had also been cancelled, spirit reached an all time peak—who goes on a tour to play sport?

Soon however it was 6 and the bar opened and discussion about the nightlife to come in Cambridge. Our intrepid Secretary, Roger Davies, spoke with intense passion and extreme verbosity, "I want to go to the disco" he said. This argument was swiftly quelled when a pint was put in his hand. So on to the nightlife of Cambridge—specifically The Mill—a pub by the river whose chief claim to fame was it's draught Abbot Ale, loved by some, tolerated by others, drunk by all.

Outside it rained, inside we drank, our spirits were low and our glasses empty. 'Let's have a game of "Clap Trap",' came the cry. The game started slowly but soon everyone joined in and soon Cambridge echoed to the slapping of thighs, clapping of hands and cry of 'Names of, Famous . . . Memories abound—Ken Harper forgetting his name, Graeme Smith unable to name an organ of the human body, the Chairman, Gary 'Gentle Giant' Calver forgetting how to start the game. Penalties increased, the landlord's smile widened, the team were happy, yet still it was only 10 o'clock. Ian Wilson and Gregg Tamlyn started the singing, the Rugby club have nothing on this. Old favourites and new versions were sung with a fervour not seen at the Liverpool 'Kop'.

Sadly the landlord did not appreciate our singing as much as we did and so with the college bars beckoning we went in search of further ale, providing the Cambridge students with the highspot of their year.

So we staggered back to Christ's to sleep on some poor students floor. Earnshaw and Smith forsaking the traditional pink elephants for flying bicycles.

The night passed fairly uneventfully with only John Rawcliffe trying to investigate man powered flight and landing on a table lamp. He was found halfway down the stairs at 4 in the morning by Jon 'who's thrown up over me' Earnshaw.

The rest of the night passed peacefully.

The next morning consisted of hangovers galore (except Ken Harper who immediately started on a litre of cider) rapidly relieved by a liquid lunch in the Cambridge Arms.

The journey back was uneventful except that Keith Underwood was last seen thumbing a lift on the A10 without his trousers.

The tour was over. No football had been played. The opposition remained hidden. But it was a tour that will never be forgotten.

GARY CALVER.

MOUNTAINEERING CLUB
GUY'S HOSPITAL
ANNUAL DINNER MEET
4-5th February, 1978

This was held at Cobelms Hotel, Capel Curig, within easy reach of the mountains of Snowdonia.

Twenty-four people went to Wales and everyone who had been on more than one mountaineering club trip in the last year was invited.

It was a relaxing if slow trip to Wales. The famous Llangollen chippy was visited for refreshment.

All the climbers were hoping that there would be several feet of snow, indeed earlier in the week all the roads to Capel had been blocked. Unfortunately the weather had turned much milder and most of the snow had melted.

On the wet, warm Saturday morning, we divided into three groups. Those who thought it really was too wet watched the Rugby International. A large number went off to the Carneddau, but due to an error in map reading (Mike Trebble's fault) they ended up having to wade across a river.

The more adventurous club members went off to climb up Bryant's Gully in the Llanberis Pass. This is 1,500ft. long and leads to the top of Glyder Fawr. On the descent Steven Morgan slipped down a snow slope, having to use an ice axe brake to stop and afterwards claimed to have been glissading.

The dinner was held in the evening

with Peter Davidson's stories going down very well. (Thanks for the wine Peter.)

On the Sunday some of us left for Scotland and climbing on Ben Nevis. The weather was miserable and as we approached the Pen-y-pass the schemes for the day became less ambitious. Peter Davidson led a successful assault on Snowdon while others went climbing on a small crag near the Pen-y-pass cafe. A safe journey back to London completed the trip.

Information about a shy girl at a party and Guy's mountaineering club can be obtained by contacting the secretary through the East Wing.

Trip lists are put up on the notice board by the bar.

N. J. MORGAN,
Secretary.

HOSPITAL INFORMATION

Royal College of Pathologists

Final Examination for the Membership (M.R.C.Path.):

H. J. H. Williams

Primary Examination:

P. B. S. Silcocks
G. Wilkinson

M.R.C.P.

R. S. Ackroyd
R. D. Armstrong
N. P. Byrom
J. J. Oram
E. M. Reuben
Miss A. Z. S. Rohatiner
C. B. Vulliamy

ROYAL COLLEGE OF SURGEONS OF ENGLAND

Diploma of Fellow of The Royal College of Surgeons of England

E. G. Latimer-Sayer
N. J. Astbury
N. J. Marks
M. S. Sorefan
H. W. Holliday
P. M. Mowschenson
P. T. Calcert
D. R. M. Campbell

M.R.C.S., L.R.C.P., January 1978

Archer, C. B.
Boone, D. L.
Britton, J. R.
Coates, R.
Entwisle, I. D.
Gaunt, P. N.
Henderson, Miss F. J.
Johns, A. R.
Pain, J. A.
Rooney, Miss C. I. F.
Sudell, W. A.
Twomey, J. M.
Womack, N. R.

University of London: Ph.D. MEDICINE

I. Mittra
K. M. Shamboul

Ph.D.

Margaret F. Price (Mycology)
Jenifer Wilson-Barnett (Psychology of Medicine)

B.D.S., December 1977

Bulline, Miss M. A. (a)
Burgess, Miss M. C. (b)(d)(g)
Litchfield, I. (c)
Ottey (Née Mander), Mrs. C. I. (b)(c)(f)
Sinclair, P. M. (c)(d)(g)
Smith, Miss C. J. (c)(f)
Troughton, Miss R. D. L. (c)(f)
Trounce, Miss G. E. (b)
Wagaiyu, C. K. (e)

(a) Distinguished in Pathology and Microbiology.
(b) Distinguished in Medicine.
(c) Distinguished in Surgery.
(d) Distinguished in Pharmacology and Therapeutics.
(e) Distinguished in Prosthetic Dentistry.
(f) Distinguished in Dental Surgery.
(g) Distinguished in Orthodontics and Paedodontics.

Ash, Miss H. J.
Attenborough, H. M.
Avetoom, G.
Bennett, Miss C. Z.
Birch, Miss P. M.
Brown, Miss A. R.
Brownbridge, Miss E. M.
Bull, M. G.
Caley, S. I. M.
Chalom, D. E.
Clark, J. D.
Cole, S. C.
Evans, D. R.
Gaskell, Miss D. M.
Gibbon, Miss J. C.
Gough, I. B.
Goves, C. R.

UNIVERSITY OF LONDON

Second Examination in Dental Surgery, December, 1977

Rhoda Adam
S. Andrews
M. Billington
Karen Cooper
Edwina A. Dighé
R. A. Dobson
Amanda Edward
J. C. Moore
R. L. Plowman
Ann M. Poynter
Pamela R. Robertson
P. G. Robinson
P. J. A. Sanders
A. M. Singer
Patricia E. Tamlin
Lynn Mary Taylor

Third B.D.S. November, 1977

Honours:

Michelle A. Bulline
Mary C. Burgess
I. Litchfield
Carol I. Mander
P. M. Sinclair
Christine J. Smith
Rosamund D. L. Troughton
Gillian E. Trounce
C. K. G. Wagaiyu

Pass:

Helen J. Ash
H. M. Attenborough
G. Avetoon
Clare Z. Bennett
Pia M. S. Birch
Anne R. Brown
Elizabeth M. Brownbridge
M. G. Bull
S. I. M. Caley
D. E. Chalom
J. D. Clark
S. C. Cole
D. R. Evans
Deborah M. Gaskell
Jane C. Gibbon
I. B. Gough
C. R. Goves
B. F. Hagan
I. F. Haley
Jane E. M. Hancock
W. H. Harley
D. C. Hughes
Hazel J. Ibbetson
S. M. Jeffries
P. N. Johnson
P. A. J. Keen
Janet F. Loch
S. R. Luxton
G. Mason
N. J. Middleton
D. L. Miller
A. Milosevic
Carol A. Nixon
Lesley M. L. Peacock
J. F. Plant
T. M. L. Ramchandani
I. Redferm
Patricia A. Reynolds
P. M. G. Rosie
Hannia I. Skapski
S. T. Stanley
D. H. T. K. Tewson
A. B. Tidman
J. R. Wells

Part I:

Susan I. Baxter
J. E. M. Bellringer
Lois A. Brereton
Anna L. Buck
Christina A. Chryssides
Helen M. Chryssides
M. G. Cliff
M. P. Cornelius
R. A. Davies
Alexandra M. Edgington
P. S. Frieberger
Moira E. E. Griffiths
S. R. Griffiths
A. C. B. Logie
M. I. Longden
M. A. B. McEvedy
G. D. Palmer
Sandra K. Robinson
A. H. Strachan
F. Suleman

Part II:

N. V. J. Barrett	Fiona M. McLean
J. A. Bell	G. R. Manning
N. S. Bhuva	N. L. Matthews
E. V. Bosch	T. A. T. Nguyen
A. V. Bramwell	P. A. Norton
N. J. Capp	Jayne A. Owen
Jane E. Carr	K. Parsons
Sarah J. Carter	N. D. Pendrey
Valerie J. Cater	C. N. Penfold
N. P. Chandler	S. G. Perkins
Chen Chun Kit	S. M. Perry
Diane I. Christopher	A. G. Pigot
J. M. Colley	S. L. C. Pimm
M. P. Cornelius	A. P. J. Pini
G. V. Cresswell	R. B. T. Price
Teresa M. Day	Erica Rapaport
Carol Dixon	A. J. Renaut
Alexandra M. Edgington	G. D. Rickard
	M. J. Rodker
H. E. Evans	R. Saravanamuttu
M. Fillery	A. E. Searle
Gillian M. Gauntlett	Jane E. Sladden
	J. G. Smerke
R. W. Gilbert	Gillian T. Smith
M. A. W. Habib	N. R. Smith
M. Hammond	Pamela A. Sugden
Kathryn M. R. Harrison	G. D. Tarrant
	C. D. Thomas
F. J. Hughes	P. Vohra
Jane A. Jordon	Kathleen Warren
C. N. Kelly	A. J. Watson
C. J. Legg	Deborah J. Watson
M. I. Longden	N. P. Willis
M. A. B. McEvedy	Kay L. Worrell
Christina H. Macfarlane	

Part III:

N. V. J. Barrett	M. A. B. McEvedy
J. A. Bell	Christina H. Macfarlane
N. S. Bhvra	
E. V. Bosch	Fiona M. MacLean
A. V. Bramwell	G. R. Manning
N. J. Capp	N. L. Matthews
Jane E. Carr	T. A. T. Nguyen
Sarah J. Carter	Jayne A. Owen
Valerie J. Cater	Deborah A. H. Pacy
N. P. Chandler	N. D. Pendrey
Chen Chun Kit	S. G. Perkins
Diane I. Christopher	S. M. Perry
J. M. Colley	A. G. Pigot
M. J. Crawley	S. L. C. Pimm
G. V. Cresswell	A. P. J. Pini
S. A. Cunnington	R. B. T. Price
Teresa M. Day	D. J. C. Rees
S. A. Des Clayes	A. J. Renaut
Carol Dixon	G. D. Rickard
J. M. Ede	Angela Rumble
Alexandra M. Edgington	R. Saravanamuttu
	N. S. Saunders
M. Fillery	A. E. Searle
J. M. Friend	A. D. Sidi
Annabel S. Gamlen	Jane E. Sladden
Gillian M. Gauntlett	J. G. Smerke
	Amanda J. Smith
R. W. Gilbert	Gillian T. Smith
S. N. Gulamali	N. R. Smith
M. A. W. Habib	Judith A. Spencer
R. G. Hahn	Pamela A. Sugden
M. Hammond	F. Suleman
M. P. R. Harben	G. D. Tarrent
Kathryn M. R. Harrison	C. D. Thomas
	P. Vohra
Jane A. Jordon	Kathleen Warren
C. N. Kay	A. J. Watson
C. J. Legg	Deborah J. Watson
A. C. B. Logie	N. P. Willis
M. I. Longden	Kay L. Worrell

Part IV:

A. S. Cayley	K. Parsons
Mignonne E. G. Davies	D. B. Patel
	A. J. Patterson
J. K. Farquharson	C. A. Pritchard
R. D. Forest	Angela Rumble
M. P. R. Harben	N. S. Saunders
R. N. Hempleman	W. R. Smithson
A. A. Matheson	Brigit M. Wilmers

BIRTHS

BRANN—On February 9th at Crawley Hospital, to Mary (née Scott) and Les, a son, Richard John Leslie.

DAVIES—To Elizabeth (née Thomas) and Christopher Davies, on 20th January, 1978, at Cardiff, a daughter, Lucy Alexandra Margaret.

DEATHS

HOLDEN—On 10th January, 1978, in the Radcliffe Infirmary, Mr. N. T. Holden, F.R.C.S.

LAWRENCE—On 10th January, 1978, Mr. Wilfred Charles Lawrence, M.Ch.(Orth.), F.R.C.S.

WACHER—On 3rd January, 1978, Dr. H. Stewart Wacher, aged 85 years.

CHANGES OF ADDRESS

Sabrina and Geoffrey Auckland, 6 Chipple Park, Lutton, Cornwood, Devon. Tel. Cornwood 471.

Mr. and Mrs. Stuart Cripps, Woodland Thatch, Quarry Woods, Cookham Dean, Berkshire. Tel. Marlow 72100.

Dr.s D. H. and M. K. Evans, 6 Old Mill Terrace, Toronto, Ontario, Canada, M8X 1A2. Office Address, 164 Queen St. E. Ste. 102, Brampton, Ontario, Canada, L6V 1B4.

John and José Prior (née Greenwood), 54 Kenilworth Gardens, Shooters Hill, London, S.E.18. Tel. 01-856 7763.

Mr. P. Hampton-Smith, B.D.S., Bickley, 61 High Street, Pembury, Tunbridge Wells, Kent, TN2 4PH. Tel. Pembury 2827 (STD 089 282).

PERSONAL

LONG ESTABLISHED London, W.1, private practice with three partners, requires experienced part-time assistant, initially for two days a week, and with a view to full time profit sharing partnership. Own laboratory, hygienist and modern fully equipped surgeries. Write Box No. 112/77.

OLD GUY'S DENTAL SURGEON requires help to look after 3 sons (16, 14 and 12 years). Boys would be at school in daytime, in order that he and his wife may have overdue holiday. House at Esher. Excellent remuneration. Temporary 10-14 days—date to be arranged. Telephone 01-398 7117.

LOCUM WANTED—GENERAL MEDICAL PRACTICE

LOCUM required in S.E. London group practice for one year from 1st June, 1978 while female partner is away. Well run practice in modern health centre adjacent to Greenwich District Hospital. Details from Dr. C. B. Challacombe, 01-858 7933.

CHANGE OF ADDRESS

Correction:

Dr. & Mrs. Christopher S. Darke, "Frenshams", Four Throws, Hawkhurst, Kent, TN18 5EB. Tel.: Hawkhurst 2140 (STD 05805).

GUY'S HOSPITAL GAZETTE

ISSN : 0017-5870 Tel. No.: 01-407 7600 Ext. 2023

EDITOR STEPHANIE A. AMIEL
ASSISTANT EDITOR RICHARD HENDERSON
NEWS EDITORS A. P. J. PINI, S. FENNY & P. J. RAZZELL
NURSING CORRESPONDENT Miss P. M. JEFFERIES
PHYSIOTHERAPY CORRESPONDENT R. J. COOPER
RADIOGRAPHY CORRESPONDENT J. GUEST
MANAGER L. PAYNE

MONTHLY 18 MARCH 1978 VOLUME 93 NUMBER 2280

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

Great Expectations

When we were small it was one of those games we used to play on wet afternoons in the classroom. Elephants, I think we called it. Now, of course, I appreciate that it is a recognised test used in psychiatric analysis —after all, I've seen them use it on the B.B.C.—and it rejoices in the name of word association. You know the routine—you're given one word and you say the first thing that comes to mind.

On the whole I think I prefer our original name for the game. A psychiatrist may like to ponder over how the term arose. To me it was merely descriptive, the words followed each other in natural succession, trunk to tail like elephants. In those days I really believed that elephants did progress naturally in such a manner. Certainly all the ones I met did !

Time definitely passed more slowly fifteen years ago. As a child, one sometimes needed something to while away the hours. I remember "Elephants" as one of the more harmless ways we used. Take the present month as an example. March. What images spring to mind? Hares—hatters—dormice? Soldier ants? Fractures—haemoglobinuria?

It is perhaps one of the least poetic months. Chaucer referred rather unkindly to the "droghte of March" (I think he meant it was dry—*how* times have changed!). Ellis described it simply as "blowy", and Shakespeare, speaking of the "winds of March", clearly concurred. Were they standing under the Guy's Tower at the time? It is presumptuous of me to disagree with such august opinion, but I do think at least one voice should be raised to the defence of this much maligned time of year.

For March is after all the gateway of spring. In fact British officialdom declares it as the beginning of summer and although they did try to remove that privilege by going on to perennial B.S.T., we soon settled down and restored the *status quo*.

I would not, of course, go so far as to declare the arrival of summer

just yet, but I do think we do March less than justice if we do not admit that here we bury winter and resurrect the spring. The evenings are lighter; the days brighter and warmer and, low be it spoken, but I have actually seen the sun. And if the daffodils that Shakespeare fondly believed to come on the wings of those winds he mentioned are still of the hot-house, pre-cut and deep-frozen variety, at least the crocuses are out now with their promise of better things to come.

March is a month of optimism. It is a time of change—for the seasons, even for the time. It is a time for shaking off the cobwebs and blowing out the dust, for washing the car and pruning last year's roses. As months go it really has quite a lot to recommend it.

A little optimism is a very important thing. I think I'll go and find those crocuses! Before it rains in April!

NOTICE

CHARITY BALL 1978

The Annual Charity Ball, run by the Finalist Students of the School of Physiotherapy, Guy's Hospital, and being held for the first time in May, is at the

CAFE ROYAL
68 Regent Street
London, W.1
on
FRIDAY, MAY 5th

All proceeds will be donated to the British Kidney Patient Association and to Riding For The Disabled.

Double Tickets (inclusive of Dinner) £14.00

Please apply to: Miss P. J. STAFFORD / OR Miss K. M. SMITH
School of Physiotherapy,
1st Floor Shepherd's House,
Guy's Hospital,
London, SE1 9RT.

Clinical Lectures—Advanced Series—Anatomy Theatre, 4.30 p.m.

April

Mon. 10	The Abortion Debate (Professor Huntingford, The London Hospital).
Tues. 11	"A Death in the Family" (Dr. C. Saunders).
Thur. 13	Respiratory Emergencies (Dr. Cochrane).
Mon. 17	The Management of Severe Burns (Mr. Broomhead).
Tues. 18	A Lady of 40 With Backache (Dr. Grahame).
Thur. 20	Sudden Visual Failure (Mr. Daniels, Dr. O'Brien).
Mon. 24	What To Do About the Confused Patient (Dr. Rosen).
Tues. 25	The N.H.S.: Myth and Reality, Dreams and Facts (Dr. Draper).
Thur. 27	Paraplegia—A Critical Emergency (Dr. Hughes, Dr. O'Brien).

May

Tues. 2	The Practical Management of G-I Bleeding (Mr. Rendall, Mr. Jourdan).
Thur. 4	Chronic Abdominal Pain (Mr. Rendall).
Mon. 8	Attempted Suicide by Overdose (Dr. Cochrane, Dr. Vale).
Tues. 9	Bed is a Dangerous Place! (Dr. Corless).
Thur. 11	The Practical Management of Psychiatric Crises (Dr. Rosen).
Mon. 15	"The Doctor in Court": Your Patient v. Society (Dr. Wall, M.D.U.).
Tues. 16	Drug Addiction.
Thur. 18	New Drugs: How to Assess the Claims.

NEWS IN BRIEF

Dental Clinical Day

More than 700 Guy's men and women came back to the dental school —new style, for annual clinical day held on 4th March. The day was a tremendous success and culminated in the combined Dinner and Ball in the Gosvenor House Hotel. We hope to have a full report in next month's *Gazette*.

Pupils' Physical Society

The first meeting of the newly revived Pupils' Physical Society was held in the Gordon Museum at lunchtime on March 2nd before an audience of over 60 students and staff. Three papers were presented by clinical students; the speakers showing excellent command of public speaking and use of visual aids. The limitation of the papers to 10 minutes each with time for questions proved a very successful format for the meeting.

Any clinical or B.Sc. student interested in presenting their work to the Society at a future meeting is asked to contact Mark Stringer or Alasdair Jacks. Prizes may be awarded annually for original papers read at a Society meeting.

The next meeting is planned for the Summer term.

Death or Glory

If you would like to be in the all-conquering Staff Football Team playing at the Summer Festival and Sports Day on Saturday, 20th May, please contact John Weinman, Unit of Psychology applied to Medicine, or Denis McCance, Microbiology Department.

Angels return

Welcome back to a splendid new crest over the main gate of Guy's. The space over our magnificent wrought iron entrance is at last restored. Denuded last year by an unfortunate accident, the gate now proudly bears the Guy's shield complete with crest and supporters. And all in glorious technicolour. Welcome home, pards. And thank you, Nick Singer.

New Chairman for Clubs' Union

Congratulations to Mr. T. L. T. Lewis on his recent election to the Chair of the Clubs' Union. And many thanks are surely due to the retiring chairman, Dr. Wells, who has ruled (and enlivened) so many meetings in the past with a just and wise hand.

Thames Boat Trip

There will be a **FLOATING DISCO** on one of the Thames cruisers on Tuesday, 21st March, leaving Tower Pier at 8 o'clock. Single tickets are available for £2.60 (no doubles) from Debbie Brook, Mary Illingworth or Barbara Pilkington, c/o Boland House, and are inclusive of a buffet. A bar will also be available on the boat.

Guy's Hospital Summer Festival and Sports Day

A reminder that this will be held on Saturday, 20th May, 1978, at Honor Oak Park. The event will involve a number of side shows, along with numerous serious and light-hearted sports events. There will be extra quantities and types of beer and the day will end with a live band and disco.

Dates from the Medical Diary

Friday, 17th March—Entries close for the Beaney Prize in Histopathology.

Monday, 20th March—Basic Medical Sciences Examination (2nd term) begins.

Wednesday, 22nd March—Examination for the Beaney Prize in Histopathology begins.

SPRING TERM ENDS—Medical School closed on Friday, 24th (Good Friday) and Monday, 27th (Easter Monday).

Wednesday, 29th March—Examination for The Beaney Prize in Immunology begins.

Thursday, 30th March—Applications for the Ian Howat Memorial Prizes and Drapers' Company Awards must be submitted to the Dean by this date.

Friday, 31st March—Entries close for the Golding Bird Medal and Prize in Obstetrics and Gynaecology.

Monday, 3rd April—Final Conjoint examination begins.

Wednesday, 5th April—Examination for the Golding Bird Medal and Prize in Obstetrics and Gynaecology begins.

Friday, 7th April—Entries close for the Goulding Bird Medal and Prize in Bacteriology.

Wednesday, 12th April—Examination for the Golding Bird Medal and Prize in Bacteriology begins.

Friday, 14th April—Entries close for the Larkin Prize in Surgery.

Monday, 17th April—Final M.B., B.S. (Old Regulations) Examination begins.

Wednesday, 19th April—Examination for the Larkin Prize in Surgery begins.

Friday, 21st April—Entries close for the Leonard Lubbock Prize in Chemical Pathology. Schedules for the Final Conjoint Examination in June must be left in the Medical School Office by this date.

Monday, 24th April—SUMMER TERM BEGINS.

Wednesday, 26th April—Examination for the Leonard Lubbock Prize in Chemical Pathology begins.

Friday, 28th April—Entries close for the M.B., B.S. (Revised Regulations) Examinations in June.

Entries close for the Leslie Hillman Prize in Haematology.

Schedules for the Final Conjoint Examination must be left in the Medical School Office by this date.

Dates from the Dental Diary

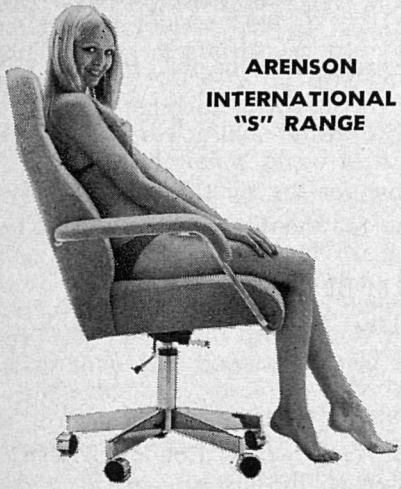
Friday, 17th March—Applications for the third B.D.S. Examination, Parts I, II, III, IV and V (obtainable from the Medical School Office) must be left in the Medical School Office not later than this date.

Thursday, 23rd March—Entries close for the Preliminary Examination for studies in Medical Subjects.

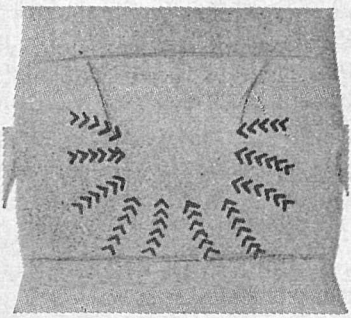
Thursday, 23rd March—SPRING TERM ENDS.

Friday, 24th March—(Good Friday) } Medical School

Monday, 27th March—(Easter Monday) } Office Closed



ARENSON INTERNATIONAL "S" RANGE



Back rest showing lumbar pad

One of the Executive chairs which has been orthopaedically designed by one of the world's leading authorities on back troubles.

bosp

OFFICE FURNITURE LTD., BEELINE HOUSE, FARWIG LANE, BROMLEY, KENT. 01-464 4452

bosp GROUP

OFFICE STATIONERY
01-460 9811

FURNITURE
01-464 4452

MACHINERY
01-460 9811

PRINTING
01-460 2257

BROMLEY - KENT

A Telephone Call to the above numbers will bring Advice and Service to your door

Friday, 31st March—Applications for the Second B.D.S. (July) Examination (obtainable from the Medical School Office) must be left in the Medical School Office not later than this date.

Monday, 3rd April—Final L.D.S. Examination begins, Part II (Dental Prosthetics) begins.

Monday, 3rd April—Applications close for the Final L.D.S. Examination Parts I and III.

Tuesday, 11th April—Applications close for the First L.D.S. Examination.

Friday, 14th April—Applications close for the Third B.D.S. Examination, Parts I, II, III, IV and V.

Monday, 24th April—SUMMER TERM BEGINS.

Friday, 28th April—Applications close for the Second B.D.S. (July) Examination.

Discount on Records

Henry Stave, 29 King William St. (Just across London Bridge), who deal mainly in classical records, are offering 10% discount to Guy's students on production of a Student Union card and to staff on production of suitable identification.

Open Door on Dysphasics

On Monday, 20th March, at 10.40 p.m. a programme in the B.B.C. *Open Door* series will offer dysphasic adults an opportunity to express themselves. Many dysphasics attend the speech therapy centre of the Kingden-Ward Speech Therapy Trust in Blackfriars Road from all parts of London, as well as from the Guy's group. A repeat will be shown on Saturday, 25th March in the early evening.

CLUBS' UNION NEWS

Broadening the Clubs' Union

Clubs' Union Council is examining in some detail the possibility of extending full compulsory membership of the Clubs' Union to the student physiotherapists, radiographers and radiotherapists. Let me explain why.

Guy's differs from most universities in that the medical and dental students are separated off from those studying other subjects. Their courses are extremely vocational and they are expected to work hard leaving little time to develop other interests, although of course many do to their credit. But they do not have the regular incidental contact with individuals of widely differing interests, studying subjects quite outside the scope of medicine: contacts which cannot but be beneficial. This incidental contact, the exchange of thoughts and ideas, the comparison of aims and goals in life occurs outside working hours; in the bar, in pubs, at parties, while producing plays, or organising dances—anywhere except at work. It is for this reason that the Union, any Students' Union, is so valuable and why it is an integral part of university life.

Guy's misses some aspects of this life, aspects which cannot ever be wholly remedied, although they are probably compensated for in a variety of other ways. But to enlarge the Union slightly by drawing into it other students on the campus must promote the exchange of ideas and different opinions so necessary to an *education,* as opposed to a training. Doctors must be educated people, not merely technicians; they must have opportunities to read, and consider thoughts which do not come within the narrow confines of their training, broad as it is in certain respects.

Certain members of the Council have expressed an opinion to the effect that *associate* membership is the answer. Under this scheme, the physios and radios will be able to participate in all the clubs and societies of the Union but will be unable to share the responsibility that goes hand in hand with organising them. Likewise they would be unable to help in the Union itself, unable to decide how money should be spent, what entertaintainment should be booked; unable to participate fully in other words. But more than that they would soon be considered second class members, which in its turn would inhibit the free expression of thoughts and ideas. Associate membership defeats completely the object of membership in the first place.

Who knows, in a few years time, with the level of communication increased between the various disciplines involved in curing and caring for a patient, perhaps the patients will be better off. And should that develop then there is a strong case for suggesting that the *training* of doctors is intimately tied up with the *educating* of medical students.

There are undoubtedly many issues to be considered, not least being the amalgamating of non-university students to an organisation that is part of London University. However not all is lost on that front, for if I might quote from the redrafted scheme of management of the Medical School in 1972 which states under the powers and duties of the Council of Governors:

"To co-operate or amalgamate with any other school, association, institution or body carrying on work similar to that carried on by the School, provided that while the School remains a School of the University no such co-operation or amalgamation shall take place without the consent of the University."

To go to the University for this purpose is undoubtedly a lot of work. But is the University not there to promote education? Isn't this proposal completely in accordance with its aims as an institution of higher education? Are we not fully justified in pursuing these aims with some force?

We would welcome any comments on this proposal.

David Denning,
President, Clubs' Union.

MATTHEW TAYLOR

We were shocked and saddened by the recent death of Guy's medical student Matthew W. B. Taylor. This tragedy was the result of a motor-cycle accident on 5th March. We extend our deepest sympathy to his family and friends.

OBITUARY

EMILY ELVINA PRIMROSE MacMANUS, O.B.E.
17.4.86 to 22.2.78

A tribute from Guy's Hospital Nurses' League

Mere words cannot pay adequate tribute to Emily MacManus. She has made her own mark in the annals of History, and indeed in the history of Guy's Hospital—the Greatest Lady, second longest serving Head of the Guy's School of Nursing, the fourteenth Matron of Guy's Hospital, the beloved President of Guy's Hospital Nurses' League.

Emily possessed many talents, some of her greatest being, wisdom, humanity, intellectual ability and versatility. Small in stature, dynamic in pesonality, she soon became internationally famous. Her book, the first to be written on nursing administration, has been the Bible of many young administrators since. Her favourite words were "By their deeds shall ye know them" and "Never let the sun go down upon your anger". What wisdom in those words and what inspiration to those holding authority!

Emily was a courageous person, unafraid and undaunted by the tremendous tasks she had to face in her life. She served in two world wars—in the first as a sister in Queen Alexandra's Nursing Service. Twenty years later, in the Second World War, she was Sector Matron covering a large part of south east England, working long hours, and driving her car many miles through much danger. We recall with affection how, despite the magnitude of her work, she never failed to ring up Guy's before retiring at night, seeking news of us and leaving her love and words of kindly encouragement. Her personal troubles always came second to Guy's.

Emily was sometime President of The Royal College of Nursing, a member of the Committees of The National and of The International Councils of Nurses. The fact was that Emily could charm and enhance any occasion with her presence, not a point was ever missed, humanity and accuracy always came through, helping many in adversity.

At home, as President of the Guy's Nurses' League, she was ever conscious of the personal love Guy's nurses had for her. Her very presence engendered the Guy's family spirit. She gave us much pleasure and we were so proud and uplifted by that brilliant mind and sense of humour. To the end of her days she remained "Matron of Guy's".

In 1946, she returned to her own beautiful country and to the County of Mayo, where she was held in great esteem. Her friends from all walks of life welcomed her return. Of her it is truly said that she "walked with kings nor lost the common touch".

Emily enjoyed her well-deserved retirement pursuing her hobbies—caring for people and animals, writing, rowing her boat. She fished in many waters over the years, always looking for the kind of people who would make good nurses and for men who would help in the training of these, no less than for the salmon and trout in her own Lough Conn.

But her interests were many. She was, for example, an ardent member of The Kipling Society. In her late eighties she still came to London to attend their meetings. I can hear her beautiful voice reading:—

"It may be that Fate will give me life
and leave to row once more—
Set some strong man free for fighting
as I take awhile his oar.
But today I leave the galley, shall I curse
her service then?
God be thanked! Whate'er comes after,
I have lived and toiled with men."

So many of us who knew and loved her will be sad at her passing—the end of such a great era.

We must rejoice with her now, as a few days before she died I had a dictated letter from her, recalling some of the old happy days, but saying, "I wish God would call me to join the others."

She has her wish. A wonderful standard of service.

The epitome of the Guy's Motto:

Dare quam accipere

Our wish for her : May she rest in Eternal peace.

L.R.S.T.

MARY DOROTHY SHERIDAN

Mary Sheridan at the time of her retirement from the Newcomen Centre. The cake was decorated with some of the letters and toys used in the STYCAR developmental tests.

Dr. Mary Sheridan, who died suddenly on February 14th, 1978, aged 79, played a leading part in establishing the importance of developmental paediatrics, and in improving the care of handicapped children. She worked at Guy's from 1964 to 1969.

She qualified from Liverpool in 1922, and spent the greater part of her working life in the school health service, in the Children's Department of the Home Office, and in the old Ministry of Health. In 1964 she came to Guy's as honorary consultant paediatrician in the Newcomen Centre, which had newly been started by the late Dr. Ronald MacKeith. After retirement from Guy's, and considerably crippled by arthritis, she continued her research in child development at the Nuffield Speech and Hearing Centre, and she remained active to the end, having been lecturing in Ireland shortly before her death. Despite her infirmities in her last few years, she was always delighted to teach, to lecture, or simply to talk about research and observations on child development.

Mary Sheridan's work has had a major influence on the practice of paediatrics and child health. As a clinical medical officer she felt the need for straightforward tests of vision, hearing and cognitive development in young children. Finding that the current paediatric text books did not provide them, she devised them herself by combining her loving and attentive observation of young children with a highly intelligent and ingenious ability to convert young children's play into reliable methods of testing. The result was the STYCAR tests—Sensory Tests for Young Children and Retardates. (Surely we should now call them the Sheridan tests.)

Her enjoyment in watching and tabulating the development of normal young children was matched by a deep concern for the needs of those who were handicapped. She did much to increase the interest and involvement of the Ministry of Health, and of paediatricians and other child health doctors, with this disadvantaged and often neglected group of children.

Those who worked with Mary Sheridan sometimes felt that her work was not as widely appreciated as it should be outside the circle of those interested in developmental paediatrics, or outside the United Kingdom. There were two possible reasons for this. Firstly, her methods of testing seemed so simple that inexperienced doctors would often think they could not be as reliable or informative as methods using sophisticated apparatus and technology. In fact they are much better, because they tell one much more about the child's own functioning. Secondly, she stood firmly on the ground of her own clinical experience, and would sometimes express impatience at numerical and statistical studies. In doing so she did less than justice to the scientific quality of her own work, which was punctiliously accurate and free from speculation or prejudice. In any case her colleagues have no real reason for thinking that her work was underestimated, and she received many honours, including the O.B.E., the Harding Award of the Central Council for the Disabled, and the highest award of the British Paediatric Association—its James Spence Medal. The memorial to her work which would have pleased her more than any of these is her lasting influence on the teaching and practice of paediatrics. The "Stycar Chart of Developmental Sequences" is one of the essential pieces of literature given to every Guy's student before he starts the paediatric firm. Mary Sheridan's methods are a fundamental part of the teaching of undergraduate paediatrics and they are used daily in infant welfare clinics and in specialist centres for paediatric neurology and handicapped children, like the Newcomen Child Development Centre.

Developmental Paediatrics has lost two of its giants within a few months —Ronnie MacKeith and Mary Sheridan. Guy's can be proud that they both worked here, and that their work continues to be built upon. R.J.R.

"RUDDIGORE"

1st — 3rd March, 1978

or "The Witch's Curse", performed by Guy's Hospital Gilbert and Sullivan Society

For some reason or other the designer of the programme for this production titled the front cover—Guy's Hospital's "Gilbert & Sullivan Society" (all the punctuation marks are his). This suggests that he felt that the expression within the inverted commas was either a quotation or was slang. If it was slang which he had in mind, then Eric Partridge in *Usage and Abusage* suggests that slang is used for one of sixteen reasons. These include: sheer *joie de vivre* by the young in spirit as well as by the young in years; "just for the hell of it"; playfully; waggishly; as an exercise either in humour or in wit and ingenuity; to be different from others; to be novel; to be picturesque; to be arresting, striking or even startling. All of these are apt descriptions of the actual production and presentation of "Ruddigore", performed by the Society in the Greenwood Theatre.

To be hypercritical would be churlish. What right has a critic to turn up for just two hours and then make snide comments about a presentation which has been gestating for many weeks? Surely he can appreciate the hours of work which have been put in by singers, producer, musical director, stage staff, props makers and ticket sellers. Why then is he thinking of being so nasty? The answer is that he does appreciate all this splendid team effort, and is only distressed when there is any possibility of the Society falling short of the high standards which have been built up over the past six years since the Society was re-founded. This production almost fell due to the random appearance, both literally and musically, of borrowed, unrehearsed, orchestral musicians. (I gather that by Friday things had improved, but they usually do after rehearsals!) The cast, the production team and the stage staff were

all Guy's persons—but where were our orchestral musicians? Prominent, I'm sorry to report, by their absence.

Nevertheless, despite the orchestral shortcomings (some of which were excruciating), the well-rehearsed soloists and choruses, under the baton of Nigel Pendrey, rose above these difficulties to produce three evenings of excellent entertainment. The Society was fortunate in having Christine Ambrose as rehearsal pianist. She also appeared in the pit during the performances and did much to alleviate the problems generated by the itinerant orchestra.

Amongst the neat sets, created under the aegis of Amanda Smith by Ian Page, Adam Skinner, Ian Crate, Kerry da Cunha and Gillian Smith, and nicely lit (the sets that is) by Amanda Ball, Jim Clare and Paul Wooley, the chorus of professional bridesmaids were eager to act out their rôle, their delightful paper posies at the ready. Similarly the bucks and blades sang with gusto and danced with elegance, in routines which were gracefully choreographed by Clare Allen. The men's chorus also appeared as the ghosts of the Murgatroyd ancestors, and the transition scene from their portraits to themselves was cunningly executed. Both choruses were particularly effective in the singing of the madrigal at the end of Act I.

Stars of the show included the"old stager" himself, Sean Tighe as Sir Ruthven Murgatroyd, putting yet another epinician role under his G & S belt. After last year's success behind the baton, this year Adam Searle appeared on stage as Richard Dauntless, a Man-o'-War's-Man. His characterisation and delivery of the nautical *double entendre* was most successful. As a man-of-many-parts, he was also the musical director, and much of the success of this presentation was his responsibility.

Both Sir Ruthven and Richard Dauntless plight their troths to Rose Maybud, who was skilfully portrayed by Jayne Owen, with just the right amount of flightiness. Peter Sanders as Sir Despard Murgatroyd was another excellent character performer, his transformation from being a very abandoned person to the ruler of a Sunday School, was entirely credible. A delightful cameo role was admirably fulfilled by Gilly Dobson as Mad Margaret. Miss Dobson's added athletic prowess was put to the test on several occasions, not least in her back summersault. Other fine characterisations came from Jon Wilde as the "Steptoe-like" Old Adam Goodheart, from Judy Weever as Dame Hannah and from Richard Gilbert as Sir Roderic Murgatroyd.

The overall production by Sarah Janikoun was a very creditable effort, and the experience gained in this presentation should lay the foundations for many successful future productions.

David Brown.

I must admit, I missed the national anthem as played before "Pirates". As well as providing a warm-up for the orchestra, it provided rare entertainment for the audience. However, after initial extemporisation by the string section, the orchestra settled down well, under the capable baton of Nigel Pendrey, to accompany Clare Allen's excellent choreography and Sarah Janikoun's fine production.

Despite the lack of volume from the huge chorus of professional bridesmaids, both choruses sang and danced with vigour and evident enjoyment.

Sean Tighe—as always original in his interpretation—gave a fine performance as Sir Ruthven; the lynch-pin of the production, but even he came second to the extraordinary performance of Mad Margaret, Daft Madge, Poor Peg, Gilly Dobson. While the part is a good one, she took it and brilliantly transformed it into the unique Dobson mixture of zany humour, contortions, and facial expressions. Jayne Owen proved herself a great addition to the Society as an all-round performer. Her Rose Maybud was a refreshing change from the usual cloying Gilbertian heroine. Adam Searle and Pete Saunders both made strong impressions in their debuts as performers; their acting and dancing talents were very enjoyable. Jon Wilde was excellent as Old Adam, and Judy Weever as Dame Hannah coped competently, a hard part for her to play. Her duet with Sir Roderic was musically one of the high spots of the evening. Richard Gilbert was nice and evil as Sir Roderic, with his band of merry spectres enthusiastically played by the Dental Squad (with the odd medic!). His duet with Hannah revealed his good voice, which rather went by the board during the ghost song, though he made up for it by being thoroughly nasty!

All in all an excellent evening's entertainment all round. However, I would like to criticise the audience. It is polite to be quiet during the overture, on all three nights the buzz of chatter persisted throughout the music, which though not up to Covent Garden standards, was still sufficiently recognisable to be enjoyable.

Alcibiades Skinner.

ISSUES IN HEALTH GROUP—ONE YEAR ON

John Balazs

The Issues in Health Group, the most recently accepted constituent member of the Clubs' Union, was set up in the Autumn of 1976 to emphasise aspects of Health which, in the overcrowded Medical Curriculum, are normally neglected. These subjects were successfully examined by holding monthly speaker-meetings and, more recently, seminars during term time. Speakers have included Professor Peter Townsend on "Poverty and Health"; Professor Roy Spector, Professor Tim Clark and Dr. Peter Draper on "Admissions to Medical School"; Diane Plamping on "Community Dentistry" and Professor Vincente Navarro on "Medicine in Capitalism". The meetings were very informative and generally well-attended. However, one very serious shortcoming was recognised: the speaker-meetings took place in isolation without any follow up or discussions. To alleviate this problem seminars are being held (under the guise of "Wednesday Workshops"). This term, seminars have been given by community health workers including a health visitor and a community health council secretary.

Like all newly-formed groups, the "Issues Group" was faced with a number of problems. The number of consistently active people in the group has been small. The activity of the group seems to fluctuate with the imminence of examinations. Another serious problem is that the Group has been dominated by a few individuals who possess the skills necessary to organise meetings. Recently, however, the influence of these individuals has lessened with the result that more diverse interests might be expressed.

There are several interesting speaker-meetings in the near future, one of which—"Balint therapy—good for patients, better for doctors"—will be given by Marshal Marenka on the 12th of May. Later in the same trimester Sheila Kinger will speak on "Childbirth". Future seminars will include group discussions lead by Sarah Moore—an Occupational Therapist; Christopher Heginbotham—speaking on Community Psychiatry, and Janet McGuire—an ECG technician.

The Group hopes to build on last year's successes by increasing the variety of subjects tackled. We hope this will encourage more people to participate in the Group's activities, with a consequent widening of its horizons.

The Drug Companies and Health

Thursday, 16th February

The Issues in Health Group were very pleased to welcome Dr. John Yudkin, Lecturer in the Department of Metabolism and Endocrinology at the London Hospital to talk at Guy's on the 16th February. About sixty people came to listen to an informative and lively talk on the drug companies and their relation to the health problems of different populations. John Yudkin has spent two years working in Tanzania at the University of Dar es Salaam and it was during this period, as he explained, that he became interested in the patterns of disease in a developing country and the needs of the population.

More than 90 per cent of Tanzanian people live in the rural areas far from technological medicine as we know it here or as it is practised by western trained doctors in the cities. Their over-riding health problems are largely preventable: malnutrition, poor sanitation; and the inadequate living conditions need to be tackled at source rather than as they present as disease. In these circumstances one would perhaps expect that there would be little place for drug companies based outside Tanzania to promote their products there. However, the drug companies opened up the market and flooded it with products that the Tanzanians could little afford. Drugs are promoted very intensively; there is one drug sales representative to every four doctors, in this country the ratio is one to twenty. The amount of advertising each doctor is subjected to is therefore vast and the number of new drugs she or he will read about always increasing. In rural Africa it is not possible to have access to any alternative information about drugs and doctors are totally reliant on drug company literature.

In fact the number of drugs which are life-saving and really helpful in many conditions is comparatively small. Money needs to be spent on prevention of disease by public health measures and in such programmes as that for vaccination against measles. In spite of this the African edition of *Mims* contains very many drugs which it advises doctors to use inappropriately. Drugs are listed for use in conditions for which they would never be prescribed in the West and the contra indications may not even be mentioned. For example the use of anabolic steroids is recommended in children who are "lethargic". Chloramphenicol is listed as useful systemically in minor bacterial infections and although it is known occasionally to cause bone marrow depression this is not mentioned. Clonidine is recommended for the treatment of hypertension without a warning about the dangers of suddenly stopping therapy—

if the doctors are not told, the proper care of their patients and the patients' understanding of the therapy must be inadequate. The results may occasionally be disastrous.

Although circumstances are very different in this country John Yudkin went on to point out that the situation in Africa does perhaps have implications for our own health services. Certainly the methods by which the drug companies operate in the U.K. are not so different; particularly as the busy G.P. cannot possibly have time to find out about every new drug and is reliant on the promotional material of the drug companies for information. The time has come for us to think very carefully about the use of new and expensive drugs where there is an older, more tried and cheaper preparation. Moreover, although drugs are an important part of health care they do often stretch our resources which could be more effectively channelled towards the prevention of disease.

After some discussion which clearly showed how stimulating the audience had found this meeting we all left to think more carefully about the use of drugs and their relation to health.

Claire Lawton.

A PUNJABI ELECTIVE

Richard Henderson

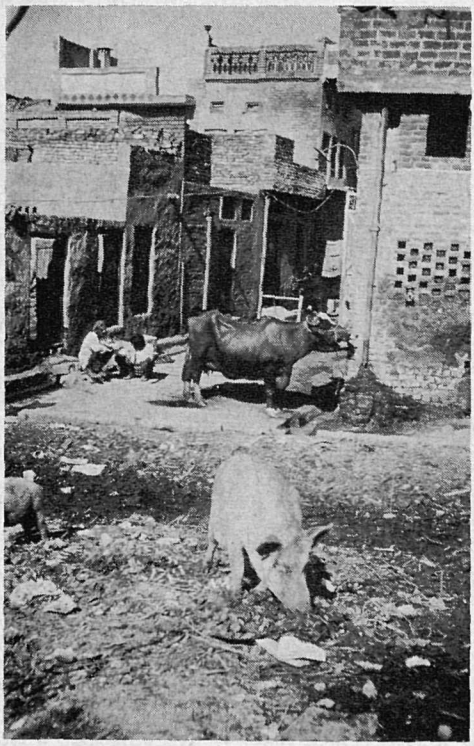
India is a vast country full of shocks and delights, and it was with some apprehension that I boarded the Jumbo jet at Heathrow. Even at that stage I was not sure how I would get to my destination—Ludhiana. Many experienced travellers had warned me of the need to book well in advance to catch a train in India, and of the unreliability of the buses. But after twelve hours in the floating cinema which aircraft seem to be now, we landed in Delhi. Sad to relate it was 2.00 a.m.; too soon to start travelling, too late to find a bed for the night. The airport gave me my first taste of Indian bureaucracy—all sorts of forms to fill in, declarations to make and documents to produce. Nevertheless, after a few hours of fitful sleep it was time to leave for the bus station—I had decided not to risk an unbooked train seat.

Kashmiri gate is the main bus station in Delhi, and the world and his wife seemed to be spending the night there. People sleeping in huddles on the ground with their possessions wrapped in a bundle beside them. Everywhere were people: people shouting, jostling, and sleeping. It immediately was obvious just how much richer we are in the West, and a source of guilt too. There I was with my new clothes and my crisp traveller's cheques, come to visit these people begging in rags.

There are two sorts of bus which go to Ludhiana, "de luxe" and "ordinary". The de luxe bus had just gone and the next wasn't for four hours, so into the ordinary bus I went, whilst a coolie balanced my case on his head, the while running up the ladder at the back of the bus and putting the case on the luggage rack on the roof. Eventually the bus left and we made steady progress along the "GT" or Grand Trunk Road to Ludhiana. The rains had finished only a couple of months earlier, and the road thus was not in the best state of repair. Furthermore the road was rather narrow and used by traffic from bicycles to bullock carts to lorries. The horn was on more than it was off as we bumped our way along holding on tight. After every pothole I apprehensively cast an eye backwards half expecting to see

my goods and chattels scattered across the road. But the driver obviously knew more about driving than I had given him credit for, as we reached Ludhiana safely and on time. (I later discovered that the Grand Trunk Road is one of the most dangerous in the world!)

Ludhiana is an industrial town of some 400,000 souls and boasting the highest per capita income in India. Even with that it has many poor people, although I suspect few compared with a city like Calcutta. Pedal power has arrived in a big way in Ludhiana (where many bicycles are made), and most people either have bicycles or move around in state in a cycle rickshaw. It was one of these that took me to the Christian Medical College, or as it is universally known, "CMC". This journey too was a test of nerve, as round-abouts and cross-roads there don't work in quite the way we expect here. At this point I realised it would be much better to preserve the sounds and smells of India rather than take photographs. Asian voices shouting, bicycle bells ringing and horns blaring, intermingled with dust and the mild smoke of slow-burning cow dung all combined to make a memorable mental image of Ludhiana.



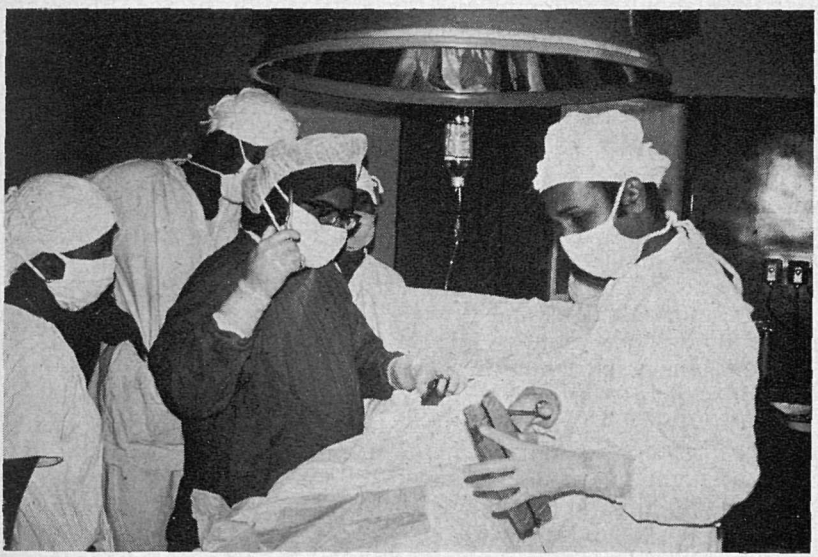
Health problems in the centre of Ludhiana.

The Christian Medical College is an oasis of quiet amidst the hurly-burly of the city. The rickshaw wallah delivered me safely and demanded 100 rupees! After some bargaining and the help of an Indian medical student this was reduced to 3 rupees. I was then shown to my rather spartan living quarters where I unpacked. I rapidly had to become accustomed to ants using the floor as a thoroughfare and lizards the wall as a hunting ground for mosquitoes. However I proceeded to settle down, was introduced to the

students, and next day to the head of the surgery department, to whose firm I was attached.

The Christian Medical College at Ludhiana is one of only two in India, the other being at Vellore in South India. Dr. Edith Brown founded her hospital in Ludhiana in 1894, and it grew into the Women's Christian Medical College. Her motto was "My work is for a King", emphasising that her first loyalty was to Christ, rather than to the temporal ruler, the Queen Empress. It remained a women's hospital until the partition of India in 1947. Ludhiana had been a largely Muslim city, and was the scene of bitter street conflict. The Brown Hospital therefore opened its doors to men as well as women, and later accepted men as students. Now it is one of India's leading teaching hospitals and is a pioneer in many aspects of health care for the poor countries of the world, in particular having a thriving community health department. The staff is largely Indian and has become even more so although some expatriate missionaries still help in both the Hospital and Medical College.

The Surgery department is organised much as in this country, although the interns act rather more like senior medical students and have no direct clinical responsibility. To my surprise the disease distribution was not unlike that in the West. This may be attributed to the relative prosperity of the Punjab and to the diet rich in saturated fats. Everything is cooked in "ghee", a highly-saturated vegetable oil. There is thus a high incidence of gall stones, and so the incidence of carcinoma of the gallbladder is much greater than



In Theatre

here where it is a rarity: during one month I saw two cases there. Large bowel carcinoma is also common. Tuberculosis and its complications are of course rife, and a florid case of cervical lymphadenitis presented at out-patients as did a man with tuberculous epididymitis. The anaesthetic department is very efficiently run, and provides adequate anaesthesia even for major surgery using relatively simple equipment. In particular, ether is much used, and I saw no real problems associated with this very cheap agent.

My second month was spent with the community health department, whose head, Professor Betty Cowan, has established it as one of the best in the "third world". The area around the city, rich agricultural land, is served by village hospitals, each of which has several subcentres in neighbouring villages. For a week or two I stayed in one of the village hospitals, a modern unit of buildings amongst the fields, with neatly laid out gardens. (I was delighted to find there poinsettias growing to over twenty feet in height—the miserable specimen in my room at Guy's barely reaches twelve inches.) I shared duties with the two interns at the village hospital which involved antenatal clinics, outpatients (in the open air), home visits and visits to village sub-centres. The countryside is idyllic around Ludhiana, in contrast to the city—and I felt curiously detached cycling from one village to another past the fertile fields divided by irrigation canals. The villages gave an impression of tidiness and cleanliness, and when I was there (in December) of emptiness, as everyone was busy sowing in the fields.

The major problem facing the community is malnutrition of infants. This is not because of lack of food, for the Punjab is the granary of India; rather it is because of ignorance. Punjabi mothers do not like to give their infants solid food until their teeth appear. But this does not occur until ten months in India, and so after four months of age, when mother's milk alone is inadequate, the babies fail to thrive, further delaying the appearance of the teeth. However by three years of age the child is big enough to look for food when hungry. The aim thus is to look for poor families with children between about six months and thirty-six months of age—these are the children at risk. The families are identified in the villages by "lady health visitors", and all births are notified to the local "chawkidar" or registrar. The assistance of the "panchyat" or village council is also sought, and in one village in particular infant mortality has been reduced due in part to the panchyat's interest in "Harijan uplift".

It seems that previous projects have failed because they have descended on villages and passively offered help to mothers in feeding their children. Of course only the better-educated families respond to such schemes, and their children are not the malnourished in any event. Thus no impact was made on infant malnutrition. By contrast the Ludhiana scheme is to identify the illiterate poor families and to give these mothers advice, and to cajole them into giving their infants solid food from four months, before malnutrition appears. The results from this approach are encouraging, and it is hoped may help the birth control schemes as parents see that their children will survive to adult life. No progress can be made however in those homes where the mother practices slow infanticide. This fate is particularly a risk for high birth order daughters, because a daughter is a great drain on family finances, carrying with her a large dowry. Thus a young daughter may be ignored and not fed. One particularly harrowing case I came across was of a fifth daughter with tuberculosis resistant to first-line drugs. Her mother was asked if she could pay for the second-line drugs which would be necessary. She replied that this daughter could die, as she had four already. Fortunately the hospital was able to give her free treatment, but it revealed an attitude of mind that a Westerner perhaps would perhaps find incomprehensible.

Vaccination is another major interest in Ludhiana, the main targets being pregnant mothers and children. Puerperal tetanus and tetanus neonatorum are not uncommon, much of the blame being put on unhygienic methods used by the village midwives or "dais". Such diseases are prevented

by vaccination of mothers and by training the midwives in hygienic practice. The aim is to win these traditional midwives over rather than to oust them. DTP, smallpox vaccination and BCG are given to all children attending for follow-up in the clinics, and the response of the villagers to this is generally good, particularly where someone has recently died unvaccinated.

A pregnant mother receiving tetanus toxoid.

The community health department also runs an urban health centre in Ludhiana which aims to give the poor people of the city similar health care to that provided in the rural areas. Tuberculosis is a major problem, made worse by the local private practitioners partially treating the disease with first-line drugs which are provided free by the Government of India. These patients then need expensive treatment with the second-line drugs, and CMC cannot afford to give these away free. Hence patients must be charged at least a proportion of the cost. The problem has become more acute as less money is being sent from abroad to Ludhiana.

After two months the time came for me to leave, and it was indeed with a heavy heart that I went around the many good friends I had made, to say good-bye. India certainly has many horrors for the doctor to see, but Ludhiana is trying to reverse this, and to achieve a balance between the high technology medicine as in the modern hospital buildings of the city (which will be completed with a new obstetrics and gynaecology block), and the community health outreach in the villages and slums. In addition the Christian Medical College is a centre of Christian outreach to the people of Ludhiana, and it is appropriate that the theme of the pictures hung in the wards is "Christ the Healer".

WHAT WENT WRONG WITH THE NHS?

Sir Francis Avery Jones, C.B.E., M.D., F.R.C.P.
Consulting Physician, Central Middlesex Hospital

When the National Health Service began in 1948 I was a young consultant and I saw the NHS as a very important forward step—the next most important social advance after the introduction of the old-age pension. My view remains unchanged today, and to me the National Health Service is the hallmark of a civilised society. Looking back to those early days it is really fantastic the poor state of buildings and equipment which the NHS inherited, and no wonder, as virtually no maintenance had been done during the war

years and indeed the previous decade. The kitchens, for example, were quite incredibly old-fashioned and inadequate. I was working in a hospital where there was strong support for the National Health Service, but elsewhere there were many who had reservations and a few who were frankly hostile. The Royal College of Physicians came down firmly in support, but the BMA remained very guarded. Some senior consultants who had initially fought hard against the concept of the NHS gave it their full support once it had been approved by Parliament. For the first ten years there was slow progress, and the 2 per cent new money per year coming into the NHS was peanuts when one looked at the frightful physical structural problems. Housing, factories, schools and power stations all had to have priority over hospitals in the immediate post-war years. At Central Middlesex Hospital where I worked—an 800 bed district hospital—we had £3,500 for minor capital works each year, and I remember having to wait three years to get a wash basin put into our main kitchen after a serious outbreak of food poisoning. Nevertheless in those first 10 years there was quite remarkable progress in the distribution of specialist skills up and down the country. My colleagues worked long hours and we were tremendously well supported by the nursing staff and the general hospital staff. The administrators all knew us and we knew them. The regional boards at that time equally knew their hospital staff. In spite of all the frustrations, problems and difficulties they were exciting days and professionally very satisfying. During this time the regional boards were preparing plans for the further development of the service, when major rebuilding could begin, but some were slow off the mark. The 1950s passed by and we moved into the 60s. Enoch Powell succeeded as Minister of Health and took up the challenge of an on-going comprehensive rebuilding programme. This was very stimulating in its anticipation. More money began to come in and the 2 per cent new money moved up to 5 per cent and 6 per cent. However, for many hospitals well down the list the programme imposed a planning blight. Nursing staff salaries were extraordinarily low. The paramedical and technical staff had been left behind, but in spite of the disrepair and the salary problems morale remained high. The objective was to build up a really first-class national health service which would be the envy of the world, which would take the sting out of the economic consequences of illness for the people of this country, and which would and was indeed already providing a far better distribution of specalist skills—anaesthetists and paediatricians particularly. Year after year the number of patients admitted to hospital steadily increased and the number of beds in use decreased as better use was made of available resources and as bottlenecks were removed. At the onset of the NHS there were 2,800,000 inpatients per year in England and Wales. The last figures I have seen were 5,200,000 with 60,000 fewer beds—a record of "productivity" which can compete with other sections of the national workforce. During the latter part of the 60s there were mounting tensions with the realisation of just how far behind some sections of the hospital staff had fallen. The shabby, dingy corridors of hospitals had by now been improved, but essential deficiencies in terms of toilets, bathrooms and staff living conditions had a very long way still to go. Nevertheless the successive Ministers of Health, notably Mr. Kenneth Robinson and Mr. Enoch Powell, succeeded in infusing a sense of purpose and direction, and enthusiasm. The service remained remarkably free from inter-party tensions, apart from some difficulties about prescribing costs. This brought us up to say about 1968, and then tensions really began to escalate.

With the gigantic size of the NHS, progress has to be gradual and co-ordinated, and cannot be rushed. One has to think in terms of a 10-year plan, or longer. This simple point, unhappily, failed to be really appreciated by those with ultimate responsibility—Ministers of Health, Secretaries of State. For some Ministers of Health, but certainly not Mr. Kenneth Robinson or Mr. Enoch Powell, the appointment was seen as a stepping stone and they were too interested in short term gains which would enhance their reputation. They would seize on an idea and then sometimes against the strongest professional advice insist on its introduction on a national scale, instead of working it out gradually first with full co-operation. The Salmon reorganization of the nursing staff is an example. The committee work stage had been well done, but it just had to be studied in practice. But no, it was introduced promptly on a national scale and in no time it meant the loss of so many of our senior ward sisters to become numbered administrators. It was in fact a very serious setback for the NHS, and one which could not be unscrambled. The next example was reorganization. The principles, as enunciated, were excellent, and I certainly approved of the idea of integrating the district and the hospital, co-ordinating with the local health authorities. One did not reckon with the introduction of a nightmare superstructure of administration which virtually closed all lines of personal communication between the hospital and those who take decisions. It was not necessary to introduce the area health authority structure on anything like the scale that has happened. It is a most expensive post office with everything passing from the district to the region, with most of the letters being lost or returned. Reorganization has caused enormous frustration within the service. We have in this country many really first-class hospital administrators, but the reorganization diminished rather than increased their contribution to the NHS. In creating the new regions, areas and districts they are all put up in competition with one another, uprooted, and many finding themselves in positions to which they are unsuited by their past experience. With the introduction of the areas the good administrators were being thinned out and particularly taken away from the large hospitals where they had done such good work. At district level they have perhaps made their best contribution, and at regional level some have achieved considerable success. At area level however they have been largely irrelevant, and much fine talent has been wasted. The problems created far exceed any benefit. Politicians who look for quick dividends can only achieve this at the expense of the NHS. Perhaps they may be beginning to realize that they can have a boomerang effect.

The next main mistake in my opinion was the introduction of political dogma into the NHS by Mrs. Barbara Castle. She had done well initially in bringing up the salaries of nurses and paramedical staff from levels which should never have been allowed to have happened by her predecessors on both sides of the House. She did well to appreciate the need for a special annual grant to aim at reducing waiting lists. But the benefits which she gave the NHS made no impact on the developing crisis of confidence. Confidence is the first essential in the conduct of any affairs, and none more so than in medicine. If one has confidence in one's doctor or one's dentist, one is half-way home. It is exactly the same with the National Health Service. One must have confidence in those who lead; otherwise no one can or will give of their best. To Barbara Castle and indeed to socialists in general the pay beds were a ridiculous anachronism and had no place in the NHS, and

one can certainly build up an argument against them. There were between 1% and 2% of pay beds in the NHS hospitals. At Central Middlesex Hospital we had nine for a hospital of rising 800 beds—six general beds always in use, one psychiatric and two maternity which were seldom occupied. In every group of society, including politicians, there are a few per cent who let the side down, and this is just as true for consultants. This, together with the quite extraordinary incompetence of the BMA at that time, made it easy for Mrs. Barbara Castle to run rings round the doctors and to show them up in a bad light. This was totally unfair for the 96% or more who had worked so hard and for so long in building up the National Health Service. Furthermore, the move towards the introduction of overtime payments, bringing doctors in line with government employees, greatly eroded their position as professional men. The general practitioners were able to maintain their status as independent contractors, but this has become increasingly difficult for those working in hospital. The great problem about this relates to the very special personal relationship between patient and doctor, and taking the profession as a whole this relationship can only be preserved if the doctor can operate as an independent contractor. A minority of doctors can be fully dependent on the government of the day, but the majority must preserve their independence from complete government control. This is why it is so important to preserve private practice. In fairness the Labour Government, as distinct from the Labour Party, has not taken steps to abolish private practice, but only to separate it from the National Health Service structure. For the efficient use of limited time geographical private practice is particularly satisfactory. However, at every turn political dogma has over-ruled considerations of commonsense efficiency. I do not want to give the impression that the faults have been entirely on the side of the politicians and the department of Health and Social Security, because I do think that the profession as a whole could have handled the developing tensions far better than they did. They should have been much more co-operative right from the beginning in tackling the problem of minor surgery, and in general work that seemed less stimulating professionally. As far as the patients are concerned, this work is of great importance and should always be given as much thought and priority as the more demanding and perhaps professionally stimulating high technology. The profession should have clamped down much more firmly and much earlier on the minority amongst their numbers who abused the special privileges which the profession had as a result of their basic independence. I do not think any section of the profession, including the Colleges, can be exonerated from blame. Such comments are always much more easily made in retrospect.

The technique of government consultation with the profession in the last few years is a matter of considerable concern. There should be a meaningful dialogue with give and take on both sides, and the viewpoint of the senior responsible members of the profession as expressed by the Royal Colleges should surely be taken into account. In practice vast changes of policy in the pattern of medicine are being developed against the almost uniform opposition of our Royal Colleges. The more recent practice of putting out documents for consultation and requesting replies in a matter of a few weeks is not the way to conduct negotiations. I feel very uneasy about the way the medical pattern of services in this country is being related to norms per thousand population—norms which have been devised by the DHSS and which are then used by the regions or areas. This is an extra-

ordinarily inflexible way of approaching a difficult problem, which in fact is so closely related to local social factors. Behind these present norms is clearly the government intention to increase the provision for geriatric at the expense of acute medicine. There is some very muddled thinking here. If you reduce your acute medicine unreasonably, all you do is deny the elderly patient one chance of rehabilitation which would have prevented him becoming a geriatric incumbent. In both the two districts in London with which I have been closely concerned there has been the loss of 250 acute beds. About 100 of these beds had been anticipated or planned, but the others represent a reduction in services to the public. I see this as a difficulty arising from over-centralization from the Elephant and Castle, and there is an argument for developing services on a regional basis, allowing each a very considerable measure of independence to allow for its special geographical and social factors.

There was extraordinary failure of the Department and politicians to take note of responsible comments on the report of the Resource Allocation Working Party (RAWP). The report set out to redistribute resources to be calculated on need. This sounds absolutely right and proper, but there were two major snags. The first is that no two persons would agree on what is need, and secondly the calculations which were made were based to a large extent on standardised mortality rates, which is a most inadequate reflection of health service needs and totally fails to reflect the cost of such immensely valuable services for the public as hip replacement which has made such a great difference to the life of so many people. The RAWP committee stemmed primarily from the concern of the politicians, because they thought that London was getting more than its fair share, and this appeared so on paper, but the more you analyze the figures the more you realize the complexities. Every capital city of the world has some extra costs related to its special role. Mr. Callaghan welcomed Mr. Carter at Heathrow to our "capital city". Under the RAWP philosophy he should have welcomed him to our "South East England Regional Centre". This immensely potentially important report illustrates my contention that the profession is being by-passed on fundamental issues. There was not a single practising consultant or general practitioner on this committee. The objective of the government was to try and ensure fair shares for the health services in each region, but annual differential regional allocations have gone a long way to achieve this in terms of essential medical services. I could not understand why the politicians were fussing so much about fair shares for health services. What they should be fussing about is fair shares for health. Mortality and morbidity differences relate much more to cultural factors such as diet, housing, occupation, selective immigration, than to the relatively minor variations in the provision of health care facilities. The government policy behind RAWP is to build hospitals at the bottom of the cliff, spacing them out more evenly, instead of building a fence at the top. The full development of our National Health Service, which I have always wished to see, is fully within the grasp of this country, but it will only be achieved if we let our skilled administrators and top professional men work out the problems. The function of the Secretary of State for Health and Social Services should be to give an overall sense of purpose and direction, and not to be constantly changing course.

(From a paper given at a recent London Medical Group meeting held at Guy's.)

STUDENTS IN GENERAL PRACTICE

Professor P. M. Higgins, M.B., B.S., M.R.C.P., F.R.C.G.P.

The third of four papers presented to the 4th annual meeting of G.P.s and Hospital Consultants of the Guy's Health District.

In this article about medical students and general practice I shall briefly describe our current teaching commitments, now largely based at Thamesmead, what we have learnt from them and the implications for teaching in the Guy's District.

Two important facts must be grasped. The first is that General Practice is a context as well as a subject. Medical problems abound outside hospital: of different kinds and at different stages and in different proportions to those encountered in hospital: and problems of similar kind—patients do not cease to exist because they do not occupy a hospital bed. In addition to the opportunity to see at first hand the interplay of family, social and environmental factors and health, the community offers a wealth of clinical experience. The second important point is that if students are to have access to this clinical experience in the community then the only way they can do so in this country at the present time is through General Practice and general practitioners.

Our programme begins with students in their second term. Every Friday afternoon during that term they watch a clinician at Guy's demonstrating his particular art and on each of these afternoons twelve members of the class come down to Thamesmead. We, with the help of our patients, illustrate diseases as they occur and are managed outside hospital, how patients react to their illnesses and what they need from doctors.

Three or four students will visit a patient with perhaps severe rheumatoid disease at home while the rest of the class talk with a less severely disabled patient in the health centre; or perhaps a mother with a child recently in hospital will talk about her experiences.

In the fifth term students learn interviewing and problem-solving and receive their first practice in interviewing at Thamesmead. Every Thursday afternoon during that term twelve students come to the Lakeside Health Centre and each has an opportunity both to see his colleagues interviewing and to interview a patient himself. The "patients" are people who are currently attending the health centre for one reason or another and who have agreed to come and "act the part" of a patient with a problem seeking the help of a doctor. What problem they bring is up to them and since it is not known in advance either to the tutor or to the student there is a reality about the experience which is missing from simulated interviews. Students find this prospect stressful and challenging but there is a corresponding feeling of achievement afterwards.

During the second clinical year (the fourth year of the course) general practice makes a contribution to four out of the five firms. The Regional firm includes a two weeks experience in general practice which is generally appreciated, the paediatric firm offers an option, which up to ten students in the year may accept, to come to Thamesmead for the "away period" as an alternative to going to a regional hospital. We give them an intensive experience of children and child care in the community with as many children to see in all the different aspects of their lives—both well and ill—as they can manage. These students are a pleasure to teach since they have

selected themselves and are in general particularly keen and hardworking. Our contribution to the Urology, Dermatology, Community Medicine firm—weekly seminars—are the least satisfactory part of our teaching programme I think because they are the least clinically based. We began by trying to relate our discussions to the work of the rest of the firm and to problems that students themselves raised. A not uncommon difficulty students experience is how to respond to the patient who asks awkward questions such as "Have I got cancer?" or "Am I going to die?" or "Was the operation a success?". These sessions—and the visit to St. Christopher's that we arrange for each class—seem to be useful but we fail in our attempt to base teaching on the clinical problems they are dealing with themselves at Guy's—mainly it seems because they are not given—or perhaps feel—little responsibility for patients during this firm. Our objectives for this part of our programme are being recast.

Our biggest commitment is the General Practice/Psychiatry firm when each student attends for a whole day five times during the ten week period. The revision of the new curriculum last year cut by half our allocation of time in the firm and this is regrettable but at least it has resulted in small groups to whom for the first time we can give a clinical role. With only four to six students on each teaching day we are able to put two of them into a consulting room which their tutor of the day vacates. At first four to six patients were allocated specially for students but now, in order to ensure a good cross section of problems an ordinary surgery list is booked—the students replacing their tutor as doctor of first instance so that they see more or less the patients that their tutor would have seen including those who have asked for an appointment for the first time in an episode of illness. It is astonishing how much information can be thrown at the "doctor" I recall seeing a harassed student who just emerged from an interview with a mother and two children all with different complaints—an experience that with great self-control he described as "terrible"—most G.P.'s would feel the same. Our aim is to give students work to do, to give them responsibility and to treat them as colleagues. The student is told to do what the doctor would do: to take a history and make a decision about the problem before reporting to his tutor. The tutor usually sees the patient himself but occasionally the student can be left to carry on. He is encouraged to follow up patients and to feel that he is contributing to their care. Problems that students coped with largely on their own include enuresis in a boy of 11, a mother worried about her child's recurrent tonsillitis, a marital problem and a woman with obesity.

At the end of the morning they set off individually or in pairs to visit a patient who has sent in a call that morning and who has not yet been seen by a doctor. They attend any lunch meetings in the health centre and visiting consultants are glad to incorporate them in their clinics. I have just sent out a questionnaire to test the response of the year to this particular firm. The replies that have come in so far suggest that students see this as quite a different experience to the rest of the clinical course and usually as challenging to them as clinicians. They mostly asked for more work and more responsibility. Many of them comment on the way in which the general practitioner uses time, knowledge of the patient and the natural tendency of most acute illnesses to recover. "I suppose" said one student, "that the whole art of General Practice is getting enough experience so that you can give some treatment at the right time, so whatever treatment you give

appears to work". At first they are often too quick to translate what patients say into medical language and thus to restrict their options, assuming, for example, that a "black" stool necessarily means melaena, without checking. Very rarely one can see the embryo professional with his professional mannerisms already set: all those mannerisms will be such a handicap to him later if he becomes a clinician—the briskness, the artificial jollity, the false bonhomie, the difficulty in making contacts with people. It is astonishing in contrast how excellent most are, much better indeed than most of us were when we first went into general practice. It is one of my tasks to sit in on general practice trainees in their early months, just after their pre-registration year and I am surprised how less well they often perform than do our students and it is interesting to reflect why this should be so.

In general students welcome this responsibility which unfortunately appears to be uncommon experience for them. Too many see themselves as spectators during the clinical years and as not really involved; too many people have seen the problem before them, few will read their notes and their contribution is not seen by themselves or others as valued or valuable. Too few have realised how much scope medicine offers for the use of imagination and it was interesting to me that words like "creativity" and "artistry" came up from time to time in discussion, expressing a need that Medicine does not seem to them to answer. There is ample scope for both in general practice—which I see as an exercise in the imagination; it is not difficult to take a problem and look at it in quite a different way, often more productive than the conventional way.

I hope I have conveyed the sense that "General Practice" is a context in which to learn certain things about medicine, about problems, about people, about health, about disease, about clinical responsibility, and about ways of managing people and problems just as the hospital is another context in which to learn about these things: but a different sort of learning, about a different range of problems, at a different stage in their development. And that General Practice offers students special opportunities to take an active role in dealing with fresh problems that no doctor has yet seen.

I believe that we now have the makings of a reasonable programme; we need to develop part of it and sharpen others. I no longer have as many objectives as I had when I started but I have just a few principles: that a student should be active, that he should be given responsibility and that he should be involved as a colleague and treated as such as far as we can; that General Practice is a clinical subject and learning in it therefore has to be problem and patient-based.

Now to consider the implications for teaching in Guy's District. It is necessary if we are going to give students these opportunities to learn that we split them into small groups. To establish a similar teaching programme in Guy's District—and we need to do so since there is no better way of getting over the great divide between hospital and general practice and of showing patients that we are a united profession—we would require rooms for students to see patients on their own, GPs who are willing to help to develop and improve the programme and learn what we do and how to do it, doctors who like us are willing to recognise they have a lot to learn about teaching and about clinical medicine and support and help from hospital and medical school. Premises, rooms, willing patients, and tutors; these are the essential requirements if we are to mount a similar programme at Guy's. The gain to everyone in this district—patients, doctors, students, hospital—would be tremendous if we could do so.

FILMS

A seat in the two and ninepenny's

Want to go to the cinema? Feeling rich? Despite what everybody tells you, you don't have to go to the end of the earth to see a decent film at a good cinema for a reasonable price.

If you must pay top prices at somewhere like the **Leicester Square Odeon** or **Swiss Centre** it may or may not be worth it. At the former, you get a decent seat, screen and sound; at the latter, you sit in a cinema about twice the size of the average living-room. There is a small, poor quality screen and sound which seems to come from a certain brand of hipster tape-recorder.

This is not, however, an article on cinema quality but on cinema prices. There are the local **A.B.C.**'s and **Odeon**'s where one can see most of the movies that either are in the West End at the time or have recently been there, for about 80p or £1. If you want the grandeur and atmosphere of one of the big West-End cinemas, or want to see the big films when they first come out, then you have to pay a minimum of £1.50: (**Odeons Leicester Square** and **Haymarket, Ritz, Warner West End, Dominion** (Tottenham Court Road), **Leicester Square Theatre**), £1.60: (e.g. **A.B.C. Shaftesbury Avenue,** £1.70: (**Scenes 1 ,2, 3, 4, Swiss Centre**). Some of the bigger cinemas which have been divided up now charge £2 (e.g. **Plaza—Regent Street**). You can wait a little while and look out for **Citicenta** (Charing Cross Road) where they occasionally show two films which have previously been shown separately in the West End. (minimum price £1.50). You can wait a bit longer still because the **Times Centre Cinema** (Baker Street Tube station) always has two double bills of films shown a few years ago, that you may have missed first time round, but are nevertheless worth seeing (£1.40).

For my last comment on cinemas showing "the big films", those who are Disney fans should note that the **Odeon St. Martin's Lane,** which shows Disney productions exclusively, has seats at 80p. There are also lots of pictures from Disney films, a grotto with Snow White and the Seven Dwarfs and other attractions to keep one amused before the film.

The **Screen on Islington Green** (all seats £1.00) is very good value showing films, many shown at film festivals, by lesser known directors (especially American), plus a few films previously shown in the West End. **The Phoenix** (East Finchley) all seats £1.20, and the **Paris Pullman** (S.W.10) (90p for students Monday and Tuesday), £1.30, show films by well-known foreign directors, many of which have also been shown at the film festivals.

There are also the cinema clubs, such as the **N.F.T., I.C.A.** and **Covent Garden Cinema Club.** It costs around £2 to join each of these for a year and seats are at 60p (and 90p), £1 and £1 respectively for each showing. All are excellent value and show the biggest cross-section of films to be seen in London.

All these cinemas show late night movies, usually on Thursday, Friday and Saturday, although some have a late show every night.

Unless otherwise stated, all prices quoted here are minimum prices.

Bob Peck.

NURSING

A Student Nurse's View

Are patients really an essential part of Guy's Hospital? The undertaking is so complex and vast that it is easy to imagine that the patients form a very insignificant part and even that the machinery of the hospital would go on without them! However as far as nurses are concerned the patient is, or at least should be, the most important person in the hospital. We are constantly involved in caring for the patient during his stay in hospital, in fact, we are probably more involved with his immediate care on the ward than any other member of the hospital staff. Without patients we should all be unemployed.

However, caring for the patient on the ward is no longer such a straightforward task as it used to be. We spend a great deal of time coping with, and at times fighting, the ever-increasing amounts of paper-work which are thrust upon us from all the different administrative channels within the hospital. This, alone, is not an impossible task, but it must be remembered that any form-filling and administration comes, as far as we are concerned, a definite second to our basic patient care. On night duty we have to complete the midnight returns—an enormous piece of computerised print giving details of every patient present on the ward. Only too often do slightly irritated administrative staff telephone to ask, "What happened to the midnight returns?" which is probably the last thing a nurse thinks of when her time is already fully occupied in an attempt to give each patient the care and attention he requires. Requisition forms for deliveries from the hospital stores and forms for the repairs to equipment which has failed are also needed before anything is done about them. Day and night reports have to be written, giving details of the patients' condition and these disappear for administration purposes too.

Admittedly, the presence of the ward receptionist can help greatly in coping with all these formalities but surely her existence alone proves that she is needed, doing a full-time job, to combat many of these administrative procedures.

On asking various medical students who they felt was the most important member of the health care team, I was horrified to hear that in their eyes it was the consultant in charge of the case. As far as the nurse is concerned, the patient is the most important person; for without him, none of us would be where we are now.

The professional relationship between medical students and nurses is an uncertain one, varying from ward to ward and depending on how much we come into contact with one another during the course of the working day. Generally speaking, nurses are unaware of the medical students position and function on the ward team and so, for the most part, a vague mutual silence is maintained. How much the medical students know of our work is not for me to speculate although I should imagine that the same uncertainty exists on their part.

Perhaps it would benefit both nurses and medical students if the student, at some stage in his training, worked alongside the nursing staff for a few weeks as student members of the paramedical staff do. In this way, he could gain some definite ideas on the "nursing process" and perhaps become more understanding and tolerant towards us later on in his career.

As a final thought, perhaps every member of the hospital, staff and students alike, would benefit by reflecting occasionally and realising that we are here because the patients are here and for no other reason.

Inga Rayment.

PHYSIOTHERAPY

How to research

Successive groups of commentators have remarked on the lack of research into the remedial therapies. Not lack of their own—they have not been that self-revelatory—but a dearth of evaluation by the professions of their own methods and techniques, a failure to establish scientifically the contribution—if there is one—that time-honoured procedures make towards a patient's recovery. Failure, perhaps to contribute anything very much, other than in a purely subsidiary capacity, towards a better understanding of the effects and uses of "remedial therapeutic" measures.

It is said that there are funds available to support research by people such as ourselves, provided that projects put forward are both feasible and relevant, and who could object to criteria of those dimensions? Why, then, have therapists been so backward in coming forward?

A number of reasons can be adduced, not least that we had not realised until recently that such was indeed the case. But supposing we had always known—would we have been aware of the terms in which a submission should be couched, the protocol, the target of our submission, the nature of the acceptable?

It is rather embarrassing publicly to admit it, but few of us would have other than the most rudimentary notion of the way to go about a research project or even to recognise one if we saw it. This could be due to the way in which we have been taught, to intrinsic intellectual limitations, to excessive pre-occupation with the job in hand which precludes our taking or making time to stand back and appraise the situation, or, again, it could be that we have no pressure on us to demonstrate an enquiring attitude of mind in order to further our career.

Publish and be damned—don't publish and be overlooked. Neither of these really applies to us—if nurses don't read, then we don't write; not because of a lack of interest but because we find it hard to believe that if we know something everybody else doesn't already know it rather more so.

Too busy? Well, that is what we all say but how many times have we had to add the rider "but you should have been here yesterday" when the unlooked-for visitor drops in? There must be the makings of a Law here—something to the effect that the volume of work being performed on any observed day is smaller than that carried out on the day immediately preceding.

Intellectual shortcomings and training deficiencies may well be the culprits, but probably in combination rather than severally—a training which has failed to foster intellectual development. Too much encapsulated "truth" has been delivered and too little encouragement given to students to seek truths of their own. The signs, though, are encouraging—today's students, today's young teachers, today's courses are all orientated towards enquiry and challenge. We are on the way towards genuine professionalism, and research into physiotherapy by physiotherapists will assuredly be undertaken.

Ronald Cooper.

BOOK REVIEWS

"Children in Health and Disease" by Frederic Brimblecombe and Donald Barltrop. Pp. 880. Price £16. Published by Baillière Tindall, 1978.

The student who considers buying a book on paediatrics (or any other part of the clinical course) will ask: Is it reasonably cheap? Is it accurate and up to date? Is it readable? Will it provide enough information to satisfy me during the firm (and for me to satisfy the examiners) without swamping me with too much indigestible information?

It is a pretty demanding set of requirements, and the number of small and medium-sized textbooks of paediatrics on the market suggests that none meets them all. Barltrop and Brimblecome is a new-look and new-title version of one of the oldest—*Paterson's Sick Children,* first published in 1930. A number of authors contribute specialist chapters, and the book shows a proper concern with modern trends in child care—the emphasis on prevention, on development and on the handicapped child. All the chapters seem reasonably or very up-to-date, but the overall impression of the book is somewhat less so, perhaps because most of the chapters are disease-orientated rather than problem-orientated. They thefore consist largely of very numberous descriptions of individual diseases, and it is rather difficult to extract advice quickly about a practical problem, like the vomiting infant.

The other important failing of this book is that it is not wholly clear for whom it is intended—whether it is a broad account of important aspects of paediatrics for the student or general practitioner, or whether it is a detailed reference book for the paediatrician in training. Many of the chapters read too much like a potted version of a large textbook—the 18 page chapter on skeletal disorders deals with 48 separate conditions (many very rare) under major headings. Of course it is always easy game for reviewers to point to lack of balance in the space given to different disorders, but if this book is intended for medical students there *does* seem something wrong with giving more space, for example, to onchocerciasis than to child abuse and battering.

Matching this book against the questions in my last paragraphs, I cannot recommend the undergraduate to buy it, or to use it as his main source for learning paediatrics. It is too expensive, and though reasonably accurate and up to date, not very readable because of its condensation and lack of balance. It contains too much information about esoteric disorders and is too long for the student to read on the paediatric firm.

R. J. R.

"Human Heredity", by C. O. Carter. Pp. 286. Price £1.25. Published by Penguin Books, 1977.

The original edition of this little book quite rightly enjoyed considerable popularity. Simply and clearly-written it served as an excellent introduction to heredity and variation in man, and could be recommended not only to the lay man, but also as a primer for students of medicine and biology. The new edition will no doubt have similar success.

It is perhaps to be expected that in a book which is concerned with basic principles the text will not need to be changed to any great extent, and for the most part up-dating has been achieved by the insertion of additional paragraphs to cover some of the recent advances. However, during the last five years there have been certain areas of major development in human genetics, especially in the field of prenatal diagnosis, and it seems regrettable that this new edition does not reflect the significance and impact of these advances. Only very brief mention is made of the prenatal diagnosis of chromosome disorders, and of neural tube defects, and none at all of the prenatal diagnosis of biochemical disorders: one would suspect that the enquiring reader would wish to know, at least in outline, how these tests are carried out. Chromosome studies are a second aspect of human genetics that has advanced very rapidly in recent years, and again this is not reflected in the new edition. Indeed, the up-dating of the section dealing with chromosomes lacks care. Thus, unchanged from the original, we read, "Recently an interesting variant of mongolism has been found" . . . in fact, translocation mongolism, the point in discussion, was reported as long ago as 1960. A little further on we are told that 14/21 translocation mongolism could probably be inherited through a balanced carrier father, but that this has not yet been reported . . . it is now of course some fifteen years since the first reports were made.

Apart from these criticisms, there is much to recommend about this book and one can confidently predict that it will continue to have widespread appeal for a considerable time to come.

M. G. DAKER.

"Textbook of Surgery" 4th edition. Edited by D. A. MacFarlane and L. P. Thomas. Pp. 787. Price £8.50. Published by Churchill Livingstone, 1977.

This is a fat paperback, strongly bound and clearly printed. It is illustrated by a number of line diagrams, which are mostly clear and memorable.

There are 10 contributors, 6 of whom are from London, and the subject matter is arranged in 31 chapters in the usual way, including chest and vascular surgery, malignant disease and pain. 70 pages are devoted to orthopaedic surgery and 70 to injuries and fractures, and there is a barely adequate index.

The preface to the 4th edition describes the considerable modernisation that has been undertaken in it, as well as the reasons for going paperback for economy.

The style is very uniform—brief dogmatic statements of standard views without explanation or discussion. Most chapters start with an account of the relevant anatomy (necessary nowadays) and orthopaedics starts with a glossary of terms. There are a few recent references at the end of each chapter.

Whilst this book contains a brief and fairly reliable account of the substance of general surgery and a guide to further reading, the very intelligent medical students of today may be dissatisfied with the lack of critical discussion, and be stimulated to seek deeper information on the substance of surgery.

REX LAWRIE.

"Notes on Medical Virology" 6th edition, by Morag C. Timbury. Pp. 138. Price £2.00. Published by Churchill Livingstone.

Short and informative books on virology for medical students are at a premium, but this 6th edition of Timbury's "Notes on Medical Virology" goes a long way to fulfilling these requirements.

All the medically-important virus groups are covered as well as certain areas of the body where viruses play a major part in pathogenesis such as the respiratory and gastrointestinal tracts. The format of each chapter is similar with an introduction to the virus group, clinical features, the biological properties of the viruses, epidemiology and finally diagnosis. This final section is in the main up-to-date but I was disappointed not to see one of the more rapid diagnostic tools, immunofluorescence, given more prominence. It was rarely mentioned even though it is becoming widely used in laboratories especially for respiratory viruses. A short account of vaccines and the possible complications of vaccination is added to the end of chapters where this is relevant. Because the book is laid out as headings with short sections of text, information on a particular disease or virus is easy to look up. The contents are up-to-date with good chapters on viral hepatitis and on the more exotic diseases produced by the rabies, Marburg and slow viruses. I was surprised to see the last 3 chapters include the Chlamydia, Rickettsia and Mycoplasma group of organisms as I would consider these to be specialised bacteria. Since the author is a virologist these chapters are not up to the standard of the rest.

Students will find this book useful and it is reasonably priced and compact enough to carry in a laboratory coat.

DENIS McCANCE.

"Cancer Rehabilitation: An Introduction for Physiotherapists and the Allied Professions". By Patricia A. Downie. Pp. 205. Price £3.25 (hard cover £6.75). Published by Faber & Faber, 1978.

To give an introduction, not write a text-book, is the author's stated intention, and in the reading of it we learn quite a lot about the author herself as well as a great deal about the rehabilitation of cancer patients. Miss Downie's experience at the Royal Marsden and the London Chest Hospital and with the Marie Curie Foundation, her Winston Churchill Fellowship, and the rare award of a Fellowship of the Chartered Society of Physiotherapy, all contribute to her being admirably suited to the task she set herself in producing a book for physiotherapists about a subject they probably have seldom considered and may well feel alienated by.

Knowledge—she quotes—is the antidote of fear, and to have read this book will help to allay the fears of physiotherapists faced for the first time with the treatment of terminally ill patients. Miss Downie's attitude is summed up in her own phrase—firmness tempered with compassion—and she writes of faith and understanding, of the love of life, of realism and confidence, with a no-nonsense approach. Sometimes this veers towards a touch of arrogance and a suspicion of patronage—not towards her patients, however, for whom she obviously cares in a matter of fact, unsentimental manner.

The book will give readers unfamiliar with this work a good basic grasp of diagnostic and treatment methods and of

a general philosophy of rehabilitation. Although it is written for physiotherapists primarily it is in no way restrictive in its attitude and members of other professions could well gain from reading it. Indeed, Miss Downie firmly states that physiotherapy and rehabilitation are not synonymous, and has exemplified her point by including chapters on nutrition (by Prof. Dickerson) and psychology (by Dr. Maguire).

A useful inclusion is a list of relevant organisations both here and in North America, and another of homes and hospices, both of which will provide helpful background for the physiotherapist. So too will the advice to read, ask questions and observe—this is a good little book!

RONALD COOPER.

CORRESPONDENCE

Cover up?

Madam,

I cannot but write a strong letter of criticism of the Editor's article entitled "Constitutional Cover Up", published in the last issue of the *Gazette*. Miss Amiel is ignorant of the situation, so ignorant as completely to misrepresent the purposes of the constitutional review and include within its purview subjects such as the integration of the radiography and physiotherapy students into the Club's Union, which have not and will not be considered.

Before discarding the entire article and placing it in the waste paper basket where it belongs, I should like to rectify one inaccuracy. The staff have not offended and their presence on the Union has been, and most probably will be, for the good of the Union. But it is my opinion that in a student representative body which formulates policy regarding student opinion, then only students should vote, and specifically students who have been democratically elected. Otherwise the whole principle of student representation is lost. Regarding the management of the Union then it is quite correct that all those involved should vote, which at present includes the staff.

Miss Amiel, we haven't yet received your submission to the sub-committee, although others have been received. If you have views perhaps you could let us have a submission before we produce our report. Alternatively you will have ample opportunity to debate the issue on May 23rd at the General Meeting.

Yours faithfully,

DAVID DENNING.

Boland House,
Guy's Hospital, SE1 9RT.

Editor's reply : Mr. Denning is quite right to point out my ignorance—perhaps he would care to apologise for it, since it is his responsibility. Yes, Mr. Denning, I am ignorant of the niceties of your constitutional review, this was precisely the reason for the Passim. There has been little attempt officially to inform any of the students at Guy's of the proposals under consideration. A sentence spoken at one U.G.M., is, in my opinion, hardly proof of a concerted effort to keep Union members in the picture—especially since you are dealing with medics. and dentists who are notorious for being unable to call their time their own. More than one Guy's student was unaware of the opportunities you imply are available to present a submission to a poorly advertised sub-committee. Perhaps you should fish your Gazette *out of your waste-paper basket (where I hope it is not in company with any other opinions you do not share) and think again. I cordially invite you to make better use of our columns to advertise your meetings and your plans to all Clubs' Union members—students of Guy's both past and present. A little democracy in action*?

Finally, if I have indeed confused two issues perhaps there is a lesson there too. May I ask why so many major changes are being rushed through all at once? Festina lente, *Mr. Denning, or are you trying to cloud the issues*?

Scottish Evening—Friends of Guy's

Madam,

May I, through you, thank all concerned; artists, committee, helpers, electricians, etc., for the help given to make a very happy evening on February 9th, 1978.

In spite of falling snow and wintry conditions, we had magnificent support from our friends and various Scottish Societies, enabling us to sell 558 lucky programmes; lucky numbers being drawn by Mr. Gordon Jackson, with 369 seats filled in the Theatre.

From the proceeds, having met expenses, a cheque for over £300 was given to The Friends of Guy's.

Yours faithfully,

ENID M. HUTTON,
Chairman of the Services Branch
of the Friends of Guy's Hospital.

The Friends,
Guy's Hospital,
London Bridge, SE1 9RT.

H.O.P.

Madam,

I was disappointed to see that you had published an ill-informed, and in my view, irresponsible letter from Mr. R. J. Robinson concerning the opening times of the bar at H.O.P. He is incorrect in his assumption that the bar is supposed to be open for three hours at lunchtime and five hours in the evening. The facilities at H.O.P. are those of a club and not those of a pub, and as such the opening hours are governed by the usage of the ground by members of the Clubs' Union pursuing athletic activities. It is entirely unrealistic to expect that the bar should be staffed on weekday lunchtimes on the off-chance that students without academic or clinical duties that day may call in for a drink. Indeed it is also unrealistic to expect that the bar should continue to be staffed even after sporting occasions when the number of potential customers is less than the number of staff behind the bar. Thus the actual opening times of the bar are those suggested by the Clubs' Union Council (to which every member has access), modified by number and by circumstances at the ground itself at the discretion of the groundsman.

The Clubs' Union is particularly fortunate at the present time to have Mr. Dann and his wife at H.O.P. They have made many improvements to the ground and clubhouse over the last three years incorporating suggestions from the student body and the Clubs' Union Council. Indeed Mr. Dann plays an active part in forward planning of activities at the ground through the Athletics Clubs' Committee, at which any suggestions for improving H.O.P. are considered. It is disturbing that your correspondent has chosen to ignore the liaison machinery set up to deal with any problems at H.O.P., or even to approach the groundsman personally, but instead has indulged in a completely unjustified and unnecessary personal attack.

Yours faithfully,

S. J. CHALLACOMBE,
Senior Secretary,
Clubs' Union Council.

Clubs' Union,
Guy's Hospital,
London Bridge, SE1 9RT.

Opera at the Greenwood

Madam,

As editor of the *Gazette* I wonder whether you could help!

It is imperative that the Grosvenor Light Opera Company's production to be staged from the 10th to the 13th May, including Saturday matinee, achieves as large attendances as possible, if we are to get near the hire fee charged by the Greenwood Theatre. To do this your assistance through the editorial pages would prove invaluable.

"The Grosvenor" has been formed as an evening class under the auspices of what was then the Central London Evening Institute to perform Gilbert and Sullivan operas in the traditional form. This principal has been adhered to throughout 28 years and has resulted in performances of all the G. & S. Operas from "Trial by Jury" to "Utopia" and "The Grand Duke". The forthcoming production of "The Mikado" will be our forty-first and the fifth of this opera. Further performances will take place in July for a whole week at the Holland Park open air theatre where the Grosvenor will provide again more than half the chorus for "the professional Gilbert and Sullivan for all Company" run by two ex D'Oyly Carte principals, i.e. Thomas Round and Donald Adams. All this activity has been due to the maintenance of high standards based on regular Monday and Friday rehearsals at Bolt Court, Fleet Street, and if any of your readers would wish to join, all they will have to do is to appear on one of the two evenings mentioned at 7 p.m.

With many thanks in advance for your assistance.

Yours faithfully,

SAMUEL J. EVERTON.

6 Bolt Court,
Fleet Street,
London, E.C.4.

The gods reply

Dear Dr. Howatt,

Thank you for correcting my nomenclature—something for which Lethe water has no respect—the Leather Exchange is indeed the correct name. Becky's bar has reopened since I wrote to you at Christmas but my comments still apply, I suspect, for the place is very different.

I am flattered you should wish me to write about the feeding troughs of the Borough but my views on these places are such that anything I am likely to write would probably never pass dear Madam Editor. For those who actually prefer a solid diet we do seem close enough to the fleshpots of Central London, otherwise I would recommend everyone to cook for himself.

Good luck,

"BACCHUS."

Killing yourself by Degrees

Madam,

Your magazine has done nothing untoward to invoke the displeasure of this disreputable publishing firm, which is probably why we find ourselves writing to you. It is with great regret and not a little remorse that we feel we really ought to bring to the notice of your reader the plight of the qualified and professionally trained man at Guy's, and to the exorbitant amount of money he can eagerly look forward to at the end of the month.

Today the words "Consultant's Clinic" means exactly what it says, a waiting room full of Consultants trying desperately to make waiting-lists meet. To picture the scene needs no great intellectual dexterity . . . a waiting room . . . a receptionist . . . the patients (in this case the Consultants), and on the door the name plate of the all powerful faith healer . . . Dr. Ennals . . .

"Next please," the weighty voice bellows. "Ah . . . Mister . . . er . . . whats-is-name . . . take a seat, now tell me when do you retire . . . oh pity, now what's the problem?"

"Well sir, I hardly like to bother you but I'm finding it difficult making ends meet . . . I may be a Bachelor of medicine but I am a Father of six."

"Rubbish man, you're vocationally trained, you can't expect any more . . . now suppose you were a porter, now that's a completely different story . . . I know your problem . . . What are your qualifications?"

"Er . . . M.B. B.S., F.R.C.S., F.D.S., M.R.C.Path., D.D.S. . . ."

"Well there's your problem, you're killing yourself by degrees. That's the trouble with you chaps, you should never let schooling interfere with your education. You should try to learn some business acumen, like that Dr. Simpkins from King's . . . he's cornered the market in mail order hip replacements and dentures, he's making a fortune. So off you go, keep your nose to the grindstone . . . Oh and by the way . . . why not try and save some of the money we give you . . . who knows, one day it might be worth something."

Yours faithfully,

"SLICKER."

Anatomical Education

Madam,

It is a truism to say that education is a two-way process, viz. teaching and learning. It is so obvious that I wonder why I bother to set it out in writing. I stop wondering why, when I cast my mind back to a conversation I had in the students' bar a few weeks ago. Two clinical dental educators concluded, and a third concurred, that if the students they taught were anything to go by, the standard of teaching in anatomy at Guy's was poor. Moreover, they maintained the students' knowledge of functional and applied anatomy was practically non-existent. I countered then and I am of the same mind now that they were quite wrong in their conclusions. Here, for the benefit of other clinicians and for the note of students, is why.

Firstly, the anatomy course at Guy's is intensive, with frequent stage tests, culminating in the big test-all exam at 2nd B.D.S., which is stiff-ish and requires cramming for success. A large part of the crammed information *shown* at 2nd B.D.S. to have been acquired will inevitably be lost without continual reinforcement afterwards. Their apparent lack of knowledge is clearly the result of that. Why? Read on.

Secondly, having m e n t i o n e d the thoroughness of the examination, the time lag between the acquisition of anatomical knowledge and its practical application adds to the dilemma, and although for dental and oral surgeons anatomy is their *sine qua non* (I propose) the students often do not come to realise this until Finals or later.

Thirdly, it is difficult to teach any meaningful (i.e. time well spent) applied anatomy at preclinical level, in the circumstances of the current dental

curriculum as a whole though a little of that is taught to illustrate the relevance of what is being taught. This is because there is an (understandable) lack of insight by preclinical students, who are primarily and quite rightly concerned with learning their subjects in order to pass 2nd B.D.S. Their insight develops in the clinical situation and it is the responsibility of clinical teachers to demonstrate to students the importance of all aspects of their training when the latter are more directly concerned with the mechanics of learning and the approach of finals. It has already been stated elsewhere* that the integrated whole can only be viewed retrospectively with the established knowledge of its constituent parts.

Finally, students, teachers and practitioners have differing views and motives in joining the dental profession (and differing motivity within these aims). And when we all assemble at the Great Fountain of Knowledge there are those who will drink; others can only gargle. Is anyone gargling in the bar tonight?

Yours faithfully,

KENNETH PARSONS.

Boland House, Guy's Hospital,
London Bridge, SE1 9RT.

*OSBORN, J. W. 1976. Gazette interview. *Guy's Hospital Gazette* 90, November 27, pp. 366-373.

Boland House Blues

Madam,

It has come to the notice of many of us who use the East Wing (Boland House) that the facilities are not all that they might be. There seems to have been a deterioration over the last few years which appears to be unaccountable; this not only includes the seemingly unresolvable perennial problems but also a large number of new ones.

Nearly every student union president has made a pre-election pledge to improve the "Spit". On reflection how much has actually been achieved? The quality of food is still poor in many lines, especially at lunch time, and the quantity leaves much to be desired. Many students have become so disillusioned by this situation that they have turned to bread rolls and soup and others have been forced away to the forbidden Nurses' Home or to Borough High Street cafés for very little extra expense.

About six months ago the sugar dispensers were removed from the tables because salt had been added to some of them. I think everyone has learnt their lesson by now. When these are put out would it be possible to have salt and pepper, and sauce in the afternoons as some people like to flavour their sandwiches?

When are the tables going to be mended? A ridiculous amount of coffee and tea is spilt daily simply because the tables are unsteady. However, this may also be due to the ridiculous economy on lighting; it is impossible to read a newspaper sometimes. This spilt drink is harmful to coats and bags—how about somewhere to put these in an organised fashion?

A reason for the high prices may be that there are fewer students using the Spit during the pre-clinical holidays. The expense surely exists due to excessive staffing—perhaps contracts could be arranged to reduce staff at these off-peak times. Trade Union objection would surely be the tail wagging the dog.

Mr. Johns wrote an interesting article in last month's *Gazette* outlining the frustrations of being the Bar Secretary. He mentions the "teething problems" of the new automated system of beer delivery, but fails to give us enough facts. The system, with subsequent repairs, may cost us £1,150. This was installed with a view to reducing the amount of wasted beer, and thus correcting the loss of £25 per night. If this was the only factor then almost 100 pints of beer, less about 20 pints "ullage", were being given away as excess in "Guy's halves". This would mean at least 200 "Guy's halves" every night. With the new system installed much more ale is being poured into the sink each night due to the "teething problems". These include the facts that to pour a pint of lager into the glass it is necessary to draw off one and a half pints from the tap, spilling the excess, and faulty switches occasionally causing a non-stop flow of over 4 pints, and other times presenting only $\frac{1}{4}$ of a pint. Perhaps clairvoyant barmen could use this facility to supply the elusive half-pint of shandy. The pumps are slower and the bar staff use this as an excuse to stand about while a massive throng develops impatiently. Should we have specially trained bar staff as required elsewhere? Mr. Johns boasts new washing machines; they would have been better if accompanied by rinsing machines to remove the soap.

Before we pay for the long awaited spot-lights and dart board could we have a few more coat pegs?—there are five in the bar! The downstairs cloakroom is unusable as thieves operate unobserved. How about converting it into a locker room as found in the swimming pool changing rooms?

The clock in the bar has been broken for over 4 years!

In recent years there has been an upsurge in inter-hospital rivalry—would it be possible to have an obvious "trophy-wall" as found in other clubs' union bars? Congratulations are due to Nick Singer for recovering the Guy's crest from another hospital bar—how many people noticed it was missing from the front gates?

The snooker room is the best in the University but could we make it better by supplying straight cues for all players, functioning lights and score-boards, new white balls, which are round, and perhaps more practical ash trays? A large number of straight cues disappear for weeks to be retipped—the snooker club is surely capable of doing this simple job more quickly and, perhaps, to a better standard.

Finally, the downstairs toilets deserve a special mention. The "Gents" has been closed for over 2 weeks for repairs and has led to excessive usage of the "Ladies". The "Ladies" loo, however, cannot cope sufficiently as it also has a toilet missing (and has been for over a year). Whoever lost the "Gents" mirror 3 years ago could they please return it?

Let's hope that the recent upsurge in spirit is to be reflected by an improvement of facilities.

Yours faithfully,

T. A. UNDERWOOD
K. O. UNDERWOOD

Boland House,
Guy's Hospital, SE1 9RT.

SPORT

J. J. Earnshaw interviewed Eric Dann, Head Groundsman at Honor Oak Park Sports Ground, earlier this month.

GAZETTE: Tell us a little about your past, Mr. Dann.

ERIC DANN: I've been here now just three years. I came from the Home Office where I had been instructor in horticulture. Of course we were in a different environment looking after young men who were forced to come to us under the penal system.

They were young men from 17–21 with problems, whereas our young men haven't such problems, except passing exams into their chosen careers. They were young with lots of energy to expend, and we found that hard work helped to get rid of it. They had to prepare their own pitches and then play on them, so they had a much better insight into their games. We used to select a piece of wooded land, strip it and cultivate a pitch and then play on it. This took about three years and then we would select more land and start again. The lads were very keen and in many respects similar to the young men at Guy's. In a way it's a great pity more Guy's students don't come to H.O.P. to get rid of excess energy.

GAZETTE: Is there room for more sport at H.O.P. then?

ERIC DANN: My word, yes. The facilities are here seven days a week and really only used once a week. A few dribs and drabs are here on a Wednesday, a day which to my mind should have as much sport going as Saturday as it is supposed to be a games day for students. The staff here work to this aim, but only the Soccer Club really comes down regularly on Wednesdays; I'm afraid the other clubs don't use their pitches to full advantage—whether the dental school points system is to blame I don't know. In the summer the tennis courts are fully used, but in the winter the pitches are often not all used especially on Wednesdays. I was under the impression that Wednesday was supposed not necessarily to be a half-holiday, but a recreation time and to my mind sporting recreation is as fine a thing as a young man can do in the middle of the week. By this token I am saying that Wednesdays should be busier than they actually are.

GAZETTE: What improvements have you made since your arrival at H.O.P.?

ERIC DANN: The most obvious improvements are the planting of shrubs and much new fencing which considerably improves the appearance of the place. We've done a lot of drainage and reseeding, making the pitches far more playable throughout the whole of the season. For example, when I first came the soccer pitch used to be absolutely useless after any sort of wet weather, now at least it is playable. There is still more work to be done, the levels have to be increased over a period—so we're getting on with that.

GAZETTE: What about the social side of H.O.P.?

ERIC DANN: Well, it's a strange thing really, we were very successful at first. It's funny, young people follow each other. Students tend to go in cycles. You have a period when about twenty young men play a winter and a summer sport and are down here all the time and become a foundation bringing people here.

Up to a year ago we had those sorts of people at Guy's and it might take up to another year to get a nucleus of people who will do the same. I don't think there's enough pride—at least not in some clubs—considering their teams. A lot of them play for themselves or their team, but not for Guy's. I think there ought to be more history of Guy's sport indoctrinated into the younger students. There should be more pride in playing and winning for Guy's rather than for themselves as individuals. I think maybe we don't display enough of the past.

GAZETTE: Tell us about the summer festivals.

ERIC DANN: Oh, they are great. They have made an enormous difference especially to the younger students and also to the staff and their families. I didn't know any of the staff at Guy's or any of the Guy's administrators, whereas I know many more now because of those days.

Although we put a lot of hard work into the organisation and setting up of such a day, it's nice to be able to take an active part in the day and enjoy it.

GAZETTE: Do the students help enough to prepare these days?

ERIC DANN: Well no. I suppose it's one of the old things, they are always willing enough, but after a party the night before, no one gets up early enough to help us. We could really do with more help. The three of us here, when we have a day like that, work from 6 a.m. 'till after midnight for three nights running before the day. And afterwards the clearing up is something that doesn't even bear thinking about. It always tends to be well worth it though, for the day itself.

GAZETTE: Do you think that the female students make enough use of H.O.P.?

ERIC DANN: I'm hoping they will use it more. There's a lot of apathy amongst the young ladies. They support it as they should. But we have now erected three more permanent grass tennis courts on the high level ground which we reclaimed from the old bomb site. Also we've now got a permanent hard surface which we hope will be used by the lads for their six-a-side soccer which we want to set up for netball and volleyball. I hope this will encourage more ladies to use the facilities. After all it would probably help to bring more men down here! It might also help some of the clubs such as the Angels, the Vipers and some hockey teams to learn a few more songs. It does get pretty boring with the same old four-letter words each week. Although it doesn't worry me or my wife it would be nice to hear some other songs!

Joyce and Eric Dann

GAZETTE: What improvements have you planned for H.O..P.?

ERIC DANN: We would like to push the ground out a bit further, but before we think of that I would like to see the grounds we have used to their fullest extent. At the moment we don't seem to be under any pressure except from the soccer club who to my mind must become frustrated at playing on only one pitch for their two teams. I know for a fact that there is a nucleus of people who wish to play soccer but can't because we haven't got the facilities. On the other hand, the hockey club don't use their grounds to the fullest extent. I'd like to see a bit more pressure put on the clubs either to use the facilities provided or possibly to have a rethink about how best to use the ground. After all, use helps a ground rather

than hurts it—a pitch lying dormant isn't doing any good at all. Plus the fact that it's a very valuable asset this ground, being so near to Guy's—probably the closest ground of any hospital. So I think it really wants sorting out.

GAZETTE: What are coming social events at H.O.P.?

ERIC DANN: The only coming event, really, is the Summer Festival on the 20th of May. This year we hope it will be the best since the Summer Festival was revived in the centenary year. The accent being on a lot of serious sport plus some lighthearted sport. This year we are making it into a more festive occasion with sideshows, the bars as always with real beer and concentrating on looking after families with children. And of course running the evening with the usual entertainments. We're looking forward to a really good year. Then of course Freshers' Day is down here—that usually goes off like a rocket. So does firework night. We're praying for better weather this year, on that occasion.

During the three years we've been here we've made so many friends, not just acquaintances but people we look on with affection. And on the occasions they are in this part of the country they may suddenly turn up and visit; it gives so much pleasure to see the old faces, it really is very nice to see them. We've got nicknames for all the old boys—Sarcy and all the rest. We don't know many of the surnames. It's so nice—we feel part of the Medical School. The new ladies and lads take a lot of getting used to and that's quite strange—as you get more memories. They have to form their personalities with yours over a period of time—quite a long time. There's also definitely a different feeling looking after your own chaps from looking after a visiting team. You give the others a service of course but your own chaps become a sort of part of the family. I'm looking forward to the future years when there are past and present matches and I know everyone whereas now I only know about half-a-dozen of the past team. Over the next years there will be all our old friends coming back.

GAZETTE: So you're happy.

ERIC DANN: Oh yes, my word, yes!

GAZETTE: Thank you very much Mr. Dann.

RUGBY

Guy's 0 pts., Coventry 16 pts.
H.O.P., 4.2.78

In this morning match Coventry sent down their "Extra Firsts" and a more aggressive and enthusiastic display could have secured a notable victory for Guy's but in a lack-lustre match Guy's seemed content to play defensively. Admittedly the pitch was heavy but Coventry managed to move the ball effectively and surely Guy's must play to their backs as the strongest part of the team. The forwards also played poorly against opponents whom we matched for size for once.

Coventry, after early pressure, scored a good winger's try in the corner after some excellent ruck ball and then seemed content to kick the ball and added a further try near half-time. The second half saw a mini-revival by Guy's, but still consistent possession was not forthcoming and Coventry scored a converted try after a forward rush. The match ended as it had begun with Guy's content to contest the match on our own 25. It does not help to reflect that this match was no more ambitious in character than the England-Wales encounter in the afternoon.

Team: Wilkinson, Portelly, Hughes, Emery, Francis, Broughton, Laws, Parry, Gibson, Neill, Keevil, Beard, Brazier, Hagan, Loxton.

G. P.

Guy's 4 pts., London Irish 44 pts.
19.2.78, The Avenue

Guy's played against an Arctic gale in the first half at Sunbury and never warmed to their task. Winning virtually all the ball in the first ten minutes the Irish over-ran an unenthusiastic Guy's defence with their winger Calaspro grabbing a couple of tries. The Irish also used the wind effectively for kick and rush tactics and capitalised a Guy's reluctance to fall on the ball on a rapidly freezing ground, thus Guy's turned some thirty points down.

The second half should have produced much more for Guy's as they belatedly made a bigger effort in the pack. The opposition looked very ordinary when they were forced to run the ball rather than kick into the wind, and Portelly gathered a deserved try for Guy's after some good running on the wing. Skipper Francis also had a couple of chances, once being thwarted by the referee but three ridiculous tries were given away towards the end when isolated sorties by

the Irish again showed up Guy's tattered defence. Guy's certainly gave the opposing prospective international players a chance to shine on that Sunday.

Team: Wilkinson, Portelly, Hughes, Harris, Francis, Broughton, Laws, Parry, Gibson, Neill, Beard, Keevil, Brazier, Palmer, Hagan.

G. P.

SOCCER

Guy's 1st XI 0, Chelsea 1st XI 0

The 1st XI needing a good result to keep their promotion hopes alive, did well to halve the points in this hard fought battle.

The Chelsea side unbeaten at the top of the league were in confident form, and Guy's were also looking for some sort of result to avenge the heaviest defeat of the season in December of last year.

Due to the boilers at H.O.P. having finally given up the ghost, four teams did a reconstruction of the "Black Hole of Calcutta" before the kick-off in the ladies' changing room. On the pitch space was only slightly easier to come by, the tackling fierce and competitive. Both sides had few chances, and the match could have been won by the odd goal by either side. But once again it was good to see the team responding to heavy pressure both the defence and the mid-field playing very well together. There was also a brilliant slow-motion penalty save by Guy's 'keeper Nick Cowland to entertain the crowd. After the two worst results of the season, this game certainly gave the team that much needed lift for the final run-in.

Guy's 1st XI 3, Charing Cross 1st XI 2

The game was played in the most atrocious conditions of rock hard ground and an icy surface, even on one of the best pitches in London at Cobham.

The 1st team were given the best possible start with a truly opportunist goal by Jon Earnshaw who caught hold of a tricky volley in spite of the attention of the defender to leave the Charing Cross goalkeeper even more out in the cold.

The game was never out of Guy's control even though the score suggests the game was closer than it actually was. Ian Wilson netted the winner for Guy's, after he had kept Graham Smith supplied with useful ball all afternoon.

Graham Smith in the side for the injured Sheppard worked hard all afternoon, his speed often "wrong footing" the Charing Cross defence on the tricky surface. Two defensive errors let the home side back into the game late in the second half, but Mike Breeze's earlier sidefooted goal kept the two points for Guy's.

Guy's 1st XI 6, George's 1st XI 1

On this wet dark Saturday, a 1st team weakened by injuries to key forwards (Breeze and Shepperd), could be found somewhere in the depths of Wimbledon getting changed in a caravan-type building with enormous bay windows that meant if you wanted to hide your modesty you couldn't.

The captain of the opposition appeared at the door to ask if we had brought a ball, as they didn't have one. Such is the glamour at the top!

The George's pitch is very much like the plateau mountain in the book "The Lost World" and if the ball goes out of play ropes and crampons are needed to retrieve it, plus a great deal of physical effort that comes a bit hard after 90 minutes of football.

This game the 1st XI could not afford to lose, with hopes of the Premier Division still in mind, but it's just this sort of game that can be so easily lost.

The home side scored first, and Guy's took a very long time to settle, finally being put back in the game by a brilliantly vicious volley from the edge of the box by Simon Perkins.

Guy's took further control and completely dominated the game, but still made heavy weather of boosting their goal average, a hat-trick by Dave Lamb (who?) and further goals from Perkins and Dave Reece (in his first game for some time), kept the promotion hopes alive.

SIMON PERKINS.

U.H. CUP SEMI-FINAL

Guy's II 4, Charing Cross II 3
(After extra time)

Guy's returned to the scene of their exit from last season's Cup final determined to extend their excellent cup record of recent seasons. Jon Earnshaw, Neil Maclachlan and Dave Abraham were welcomed back to the side who arrived at sub-zero Cobham in confident mood.

The game started fast and hard with Guy's having the better of the early exchanges, going close twice in the opening few minutes. However, Charing Cross struck first to score from a goalmouth scramble after five minutes. The home side were roared on by their supporters and Guy's had to battle hard for a while. They withstood the pressure with some desperate defence and an extraordinary

save by Dave Abraham when he crawled along the goal-line like a grazing ox to head the ball away as it was trickling into the corner. Inspired by this, Guy's hit back with a goal from Jon Earnshaw after a good run and cross by Graeme Smith, who spent the rest of the first half redecorating one side of the pitch courtesy of the lower spit. Guy's suffered further misfortune as Charing Cross regained the lead somewhat fortunately, and then John Rawcliffe missed a penalty just before half-time. The first half ended with Guy's playing the better football but unable to turn their superiority into goals, so when Charing Cross made it 3—1 from the penalty spot all looked lost for Guy's.

The home side had not returned with the purpose and character of their opposition and Guy's hit back with a nicely taken goal from Jon Earnshaw after Dave Abraham had headed on a long free-kick. Now it was Guy's chance to turn on the screw as they took charge of the game with good old "kick and run" football, as snow and sleet were beginning to beat down.

At last Guy's equalised fifteen minutes from time when Dave Greenaway robbed a Charing Cross defender and put the ball through to John Rawcliffe who scored a fine goal to atone for his earlier penalty miss. Big John was not finished yet. Guy's were unable to pierce the defence again before full-time despite intense pressure and so the game went to extra time.

In extra time Guy's maintained their impetus and at last took the lead for the first time when the opposing goalkeeper obligingly fell over to leave John Rawcliffe with an open goal. After this, Guy's defence stood firm with Gary Calver and Liam Broughton outstanding, and so won a hard fought and exciting game to reach their third cup final in two years.

Guy's for the Cup.

Team: R. Evans, G. Calver, D. Abraham, L. Broughton, N. MacLachlan, R. Davies, D. Greenaway, K. Underwood. G. Smith, J. Earnshaw, J. Rawcliffe.

DAVE GREENAWAY.

SWIMMING

Last month Guy's Swimming Club had two matches against Colleges of London University. The first was against Royal Holloway College which took place on the 13th of February. Despite the heating shut-down at the weekend the pool was like a bath by Monday evening and the teams had no trouble warming up.

The Royal Holloway women's team looked like strong opposition but they were rather short of men and had to "borrow" some Guy's men to make up numbers for the relays.

After sorting out teams the races got underway with a splash! It was a close match all through with many yells of encouragement to swimmers taking part, but the final add up of points showed that both ladies' and men's teams from Guy's had won.

After the match, not quite drained of energy, everyone was back in the pool again for mixed water polo. The score-keeping got rather forgotten when the game began to degenerate into a ducking competition, but it was much enjoyed by all.

Somewhat tired out by the evening's exercise, hot soup and food on the second floor of Wolfson were much appreciated before retiring to the bar.

Results:	Guy's	Ladies	33	⎫	
		Men	35	⎭	68
	R.H.C.	Ladies	31	⎫	
		Men	27	⎭	58

Guy's Teams.

Ladies: Mary Ganczakowski (Captain), Liz Palmer, Chris Smith, Tracey Maunder, Caroline Kinlock-Jones Veronica Reban.

Men: Mike Miller (Captain), John Beard, Dave Rickard, Gabriel Teo, Andy White.

The second match was held just over a week later against University College and, as expected, they were somewhat tougher opposition. Despite a hard effort by Guy's both ladies' and men's teams were beaten by University College. The match was again followed by a mixed water polo game, just to finish everyone off! This time we ascended a little higher in the building for refreshments, up on the eleventh floor.

Results:	Guy's	Ladies	29 pts.	⎫	
		Men	24 pts.	⎭	53
	U.C.	Ladies	35 pts.	⎫	
		Men	40 pts.	⎭	75

Teams.

Ladies: Mary Ganczakowski (Captain), Liz Palmer, Chris Smith, Sara Leutchford, Caroline Kinlock-Jones, Tracey Maunder, and Sally Clark.

Men: Mike Miller (Captain), Dave Rickard, Andy White, Pete Robinson, Mike Evans, Shant Khan.

Helen Kinsella and Julie Carlton helped with the time-keeping and Martin did a fine job in starting all the races. Their help was much appreciated.

M. G.

HOSPITAL INFORMATION

Royal College of Surgeons
L.D.S. January, 1978

Harris, Mark William
Piper, Robin Mark
Wallis, Miss Sarah Isobel
Owen, Michael Robert
Ryan, Jeremy Martin
Wood, Christopher

Final L.D.S. Examination—Part I
January, 1978

Pearson, J.

The Final Examination of the Chartered Society of Physiotherapy
November 1977

Miss A. Buffham
Miss T. A. T. Chubb
Miss E. Cooper
Mrs. J. Crouch (née Richardson)
Miss J. C. Fairhead
Miss J. Fairs—Credit
Miss K. E. Gillanders
Miss A. P. Henderson
Miss H. M. Holder
Miss E. H. Jardine
Miss S. D. Langton
Miss S. A. Maynard
Miss B. A. Mitchell
Miss C. M. McIntyre
Mrs. A. P. Nashwalder (née Fowler)
Miss C. F. Ordon
Mrs. K. M. Rashbrooke (née Gilley)
Miss J. M. D. Storey
Miss R. E. Tucker
Miss E. J. Winning

The Intermediate Examination of the Chartered Society of Physiotherapy
November 1977

Miss S. K. Barrington Clark
Miss M. J. Bell
Miss J. M. Cridlan
Miss C. G. Francis
Miss S. F. Haggerty
Miss F. J. Jones
Mrs. C. M. Ratcliffe
Mrs. G. M. Russell Smith
Miss J. Scott
Mrs. A. Thomas (née Barber)
Miss A. I. Walsh

The Chartered Society of Physiotherapy
February 1978 Final Examination

Miss Barrington Clark, S. K.
Miss Bell, M. J.
Miss Chapman, L. C.
Miss Cox, C. A.
Miss Cridlan, J. M.
Miss Francis, C. G.
Miss Haggerty, S. F.
Miss Jones, F. J.
Miss Kirby, D. J.
Mrs. Russell-Smith, G. M. (nee Richardson)
Miss Scott, J.
Mrs. Thomas, A. (nee Barber)
Miss Vines, A. I.
Miss Walsh, A. I.
Miss Young, C. A.

DIETETIC DEPARTMENT
STUDENTS ACCEPTED FOR PRACTICAL TRAINING
in 1978-1979

University of London

Postgraduate Diploma in Dietetics

Miss C. M. Hadfield	B.Sc.	London
Miss M. Hathaway	B.Sc.	London
Miss S. Ho	B.Sc.	London

18 Month Diploma in Dietetics

Mrs. P. Brown	M.A.	Oxon
Miss J. Reid	B.Sc.	Nottingham

University of Surrey B.Sc. (Hons. in Nutrition)

Miss L. Fuller
Miss C. Marshall
Miss S. Pearce
Miss C. Sheard
Miss O. Wilkinson

3 and 4 Year Diplomas in Dietetics

Miss P. Daniels	Edinburgh
Miss J. Gubbins	Cardiff
Miss D. Tasker	} Polytechnic of
Miss L. Walker	} N. London

PAPERS BY GUY'S MEN

Armstrong, D. Clinical sense and clinical science. **Social Science & Medicine,** 1977, **11,** 599-601.

Anstee, B. H. and Fleminger, J. J. Diagnosis "uncertain": a follow-up study. **British Journal of Psychiatry,** 1977, **131,** 592-8.

Buisseret, P. D., Pembrey, M. E. and Lessof, M. H. a_1 antitrypsin phenotypes in rheumatoid arthritis and ankylosing spondylitis. **Lancet,** 1977, **2,** 1358-9 (Correspondence).

Carabott, F. Shadow over Maltese medicine (Correspondence). **British Medical Journal,** 1978, **1,** 112-3.

Challacombe, S. J. et al. Immunoradiometric assay of salivary anti-C_3 antibodies. **Journal of Immunological Methods,** 1978, **19,** 53-9.

Chan, K. N. Shadow over Maltese medicine (Correspondence). **British Medical Journal,** 1978, **1,** 112.

Chantler, C. Children with renal failure (Correspondence). **Lancet,** 1977, **1,** 159-160.

Chapman, S. J., Counahan, R. and Chantler, C. Management of children with nephroti syndrome (Correspondence). **British Medical Journal,** 1977, **2,** 1667.

Clayton, P. T., Counahan, R. and Chantler, C. Munchausen syndrome by proxy (Correspondence). **Lancet,** 1978, **1,** 102-3.

Crome, P., Volans, G. N., Hampel, G., Vale, J. A., Widdop, B. and Goulding, R. Haemoperfusion in treatment of drug intoxication (Correspondence). **British Medical Journal,** 1977, **1,** 174.

Day, L. J., Sowton, E. and others. Pindolol in the treatment of hypertension: a double-blind randomised trial. **The Practitioner,** 1977, **219,** 889-894.

Fensom, A. H., Benson, P. F., Baker, J. E. and others. Fluorimetric assay for prenatal detection of Hurler and Scheie homozygotes or heterozygotes (Correspondence). **Lancet,** 1977, **1,** 147.

Gregson, N. A. The surface properties of isolated rat brain myelin: a microelectrophoretic study. **Journal of Neurochemistry,** 1977, **29,** 895-903.

Hughes, R. A. C., Gary, I., Clifford-Jones, R. and Stern, M. Immune response to myelin basic protein in multiple sclerosis. **Proceedings of the Royal Society of Medicine,** 1977, **70,** 874-5.

Husband, J. and Saxton, H. M. Unnoing excretion and patterns of protein binding of ioelipamide (Biligrafin forte). **British Journal of Radiology,** 1978, **51,** 11-16.

Hutton, A. M., Wedley, J. R. and Seed, R. F. Teaching of anaesthesia to dentists. **British Dental Journal,** 1978, **144,** 35-39.

Innocenti, D. M. Breathing exercises. In Assessment of treatment for the respiratory cripple (symposium). **Journal of the Royal Society of Medicine,** 1978, **71,** 61.

Ivanyi, L. and Lehner, T. Interdependence of in vitro responsiveness of cord and maternal blood lymphocytes to antigens from oral bacteria. **Clinical and Experimental Immunology,** 1977, **30,** 252-8.

Lehner, T., Caldwell, J. and Challacombe, S.J. Effects of immunisation on dental caries in the first permanent molars in rhesus monkeys. **Archives of Oral Biology,** 1977, **22,** 393-7.

Lindsey, D. The Upper mid-line space and its relation to the labial frenum in children and in adults. **British Dental Journal,** 1977, **143,** 327-332.

Longhurst, P. et al. Differences in lymphocyte and plasm cell densities in inflammed gingiva from adults and young children. **Journal of Periodontology,** 1977, **48,** 705-710.

Lumsden, A. G. S. and Osborn, J. W. The evolution of chewing: a dentist's view of palaeontology. **Journal of Dentistry,** 1977, **5,** 269-287.

McCance, D. J. and Mims, C. A. Transplacental transmission of polyoma virus in mice. **Infection and Immunity,** 1977, **18,** 196-202.

McColl, I. Treatment of benign strictures of the oesophagus. **Journal of the Royal Society of Medicine,** 1978, **71,** 1.

Macdonald, I. and Keyser, A. Changes in blood metabolites following the acute injection of various amounts of glucose (Paper presented at meeting of the Nutrition Society, 12th September, 1977). **Proceedings of the Nutrition Society,** 1977, **36,** 117a.

Mallinson, C. The pancreas: chronic pancreatitis. **British Journal of Hospital Medicine,** 1977, **18,** 553-566.

Maton, P. N., Murphy, G. M., Dowling, R. H. Ursodeoxy xholic acid treatment of gallstones: does response study and possible mechanics of action. **Lancet,** 1977, **2,** 1297-1301.

Pickup, J. C., Keen, H. and others. Continuous subcutaneous insulin infusion: an approach to achieving normogylcaemia. **British Medical Journal,** 1978, **1,** 204.

Polani, P. E. and others. Alpha-fetoprotein in antenatal diagnosis of neural tube defects. **British Medical Journal,** 1978, **1,** 238.

Roberts, B. J. A study of the viscosity of saliva at different shear rates in dentate and edentulous patients. **Journal of Dentistry,** 1977, **5,** 303-309.

Scully, C. Orofacial manifestations in tuberous sclerosis. **Oral Surgery, Medicine and Pathology,** 1977, **44,** 706-716

Shillitoe, E. J., Wilton, J. M. A. and Lehner, T. Sequential changes in cell-mediated immune responses to herpes sompliex virus after recurrent herpetic infection in humans. **Infection and Immunity,** 1977, **18,** 131-137.

Simmonds, H. A., Panayi, G.S. and Corrigal, V. A role for purine metabolism in the immune response: adenosine-dearienase activity and deoxyadenosine cetabolism. **Lancet,** 1978, **1,** 60-63.

Simmons, N. Hair in the theatre (Correspondence). **British Medical Journal,** 1978, **1,** 111.

Stewart, I. McD. G. Coronary heart disease after treatment of hypertension. **Lancet** 1978, **1,204.**

Tomkinson, J. S. **Contemporary Obstetrics and Gynaecology,** edited by G. Chamberlain, 189-192.

Tomkinson, J. S. Inversion of the appendix. **Acta Obstetrica and Gynecologica Scandinavia,** 1977, **56,** 431-3.

Winder, E. One organ medicine. **British Medical Journal,** 1977, **2,** 1585-6.

House Appointments

1st January, 1978

House Physicians

Dr. Scott, Dr. Joiner, Dr. Grahame and Dr. Gibson	Mr. P. Emery to 14.2.78 Mr. B. Jones to 14.2.78 Mr. J. J. Horton *7 months*
Prof. Lessof, Prof. Keen, Prof. Dowling and Dr. Maisey	Miss G. J. C. George to 14.2.78 Mr. D. G. S. Collier *5 months* Mr. T. H. J. Goodship *7 months*
Dr. Houston, Prof. Trounce, Dr. Knight and Dr. Grimble	Mr. B. H. Wilkins to 14.2.78 Mr. S. A. Watson to 14.2.78 Mr. M. G. Pike *5 months*

House Surgeons

Mr. Lawrie	Mr. M. K. Bancroft-Livingston to 14.2.78
Mr. Ellis	Mr. P. H. Jarrett to 14.2.78 Mr. E. J. Dalgleish to 31.7.78
Mr. Beard	Mr. A. B. Tanqueray to 14.2.78
Mr. O'Flynn and Dr. Winter	Mr. S. Haworth to 14.2.78 Mr. J. Efthimiou to 31.7.78
Mr. Glover	Mr. R. P. Money to 14.2.78
Mr. Maynard and Dr. Tong	Mr. M. J. Tidman to 14.2.78 Mr. A. J. Davis to 31.5.78
Prof. McColl, Mr. Rendall and Mr. Bewick	Mr. A. A. Quyyumi to 14.2.78 Mr. J. D. Taylor *7 months*

Gynaecological House Surgeon

Mr. Coltart and Mr. Tomkinson	Mrs. G. M. Dick to 14.2.78
Mr. Lewis and Mr. Morris	Mr. S. K. Sinclair *5 months*

Throat and Ear House Surgeon

Mr. S. M. Milner to 14.2.78
Mr. R. H. Jones
5 months

Orthopaedic House Surgeons

Mr. C. B. Ackner to 14.2.78
Miss E. O. Breese to 14.2.78
Mr. A. K. Kapur to 14.2.78

Genito-Urinary House Surgeon

Mr. A. J. Davis to 14.2.78
Mr. M. J. Tidman to 31.5.78
Miss E. J. Dalgleish to 14.2.78

Thoracic House Surgeons

(S.H.O.)	Mr. P. H. Rowe *2 months* Mr. J. Efthimiou to 14.2.78

S.H.O. to the Renal & Transplant Unit

(S.H.O.)	Dr. A. W. Nathan *2 months*
(S.H.O.)	Dr. A. C. Davies *5 months*

Children's House Physicians

(S.H.O.)	Dr. S. M. Herber *9 months*
(S.H.O.)	Dr. P. T. Clayton *2 months*
(S.H.O.)	Dr. A. J. MacRae *5 months*
(S.H.O.)	Dr. J. S. G. Bamforth *11 months*
(S.H.O.)	Dr. A. E. Brusby *12 months*
(S.H.O.)	Dr. P. T. Rudd *2 months*
(S.H.O.)	Dr. A. H. Thomson *2 months*
(S.H.O.)	Dr. T. Y. D. Leung *5 months*
(S.H.O.)	Dr. D. J. Rose *5 months*

Casualty Officers

(S.H.O.)	Dr. K. G. Brame *2 months*
(S.H.O.)	Dr. W. C. Crozier *2 months*
(S.H.O.)	Dr. E. M. Lee *2 months*
(S.H.O.)	Dr. I. G. Nicholson *2 months*
(S.H.O.)	Dr. R. D. Perkins *2 months*
(S.H.O.)	Dr. N. D. Bardsley *5 months*

Resident Obstetricians

(S.H.O.)	Dr. S. Johnson *3 months*
(S.H.O.)	Dr. S. R. Killick *2 months*

Neurological House Physician

(S.H.O.)	Dr. S. E. Edwards *2 months*

Dermatological House Physician

(S.H.O.)	Dr. G. W. G. Vevers *2 months*

Resident Anaesthetists

(S.H.O.)	Dr. J. D. McArthur *8 months*
(S.H.O.)	Dr. S. J. P. Ariaraj *8 months*
(S.H.O.)	Dr. J. M. Evans *9 months*
(S.H.O.)	Dr. R. M. Cash *11 months*

S.H.O. to Nuffield House

(S.H.O.)	Dr. J. C. Kelly *2 months*
(S.H.O.)	Dr. J. R. Bayly *5 months*

House Physician in Child Psychiatry

(S.H.O.)	Dr. C. M. F. Dicks-Mireaux *3 months*

S.H.O. to the Cardiology Department

(S.H.O.)	Dr. R. A. Foulds *3 months*
(S.H.O.)	Dr. O. L. Duke *3 months*

S.H.O. to the Department of Ophthalmology

(S.H.O.)	Dr. R. Henderson-Smith *9 months*

S.H.O. to the Department of Psychiatry

(S.H.O.)	Dr. R. W. K. Bamber *3 months*
(S.H.O.)	Dr. P. H. Hollis *3 months*
(S.H.O.)	Dr. A. M. Leader *3 months*

ST. OLAVE'S HOSPITAL

House Physician	Mr. C. E. Handler to 14.2.78 Mr. S. F. Evans *5 months*
House Surgeon	Mr. R. S. Hurwood to 14.2.78 Mr. M. G. N. Bourne to 14.2.78 Mr. A. K. Kapur to 31.7.78
S.H.O. in Gynaecology	Dr. K. R. Mao *3 months*
S.H.O. in Psychiatry	Dr. N. P. Darroch *3 months* Dr. D. K. Roy *3 months* Dr. G. Milavic *3 months*

NEW CROSS HOSPITAL

House Physician in General Medicine with Geriatrics and Rheumatology	Mr. V. J. Kielty to 14.2.78 Mr. J. E. Bridger to 14.2.78 Mr. G. J. Murphy *5 months* Mr. C. V. R. Blacker *5 months*

BECKENHAM HOSPITAL

House Physician	Mr. D. C. Haiart to 14.2.78
House Surgeon	Mr. K. Radia to 14.2.78

ASHFORD HOSPITAL, KENT

House Surgeon	Miss S. G. Mitton to 14.2.78

HITHER GREEN HOSPITAL

House Physician in General Medicine and Infectious Diseases	Mr. A. D. Bundock *1 month* Miss N. K. Scott to 14.2.78

LEWISHAM HOSPITAL

House Physician to Dr. Price	Miss E. J. Dalgleish *1 month*
House Physician to Dr. Stott	Miss M. E. Heber *1 month*
House Physician to Dr. Staffurth	Mr. C. S.Bull to 14.2.78
House Physician to Dr. Llewellyn-Smith	Miss J. Glover to 14.2.78
House Surgeon to Mr. Lynn Evans	Miss V. Pain *6 months*
House Surgeon to Mr. Ivo Smith	Mr. J. C. Kingswood *1 month*
House Surgeon to Mr. Monty	Mr. B. A. Price *1 month*
House Surgeon to Mr. Le Brun	Mr. P. W. Timms to 14.2.78
House Surgeon to Mr. Negus	Miss H. M. Earl to 14.2.78

ORPINGTON HOSPITAL

House Surgeon to Mr. Wilding and Mr. Lam	Mr. R. G. Evered to 14.2.78 Mr. G. Sengupta *6 months*
House Surgeon to Mr. Walker-Brash and Mr. Ratnesar	Mr. V. G. Thornton *6 months*
House Surgeon to Mr. Boxall and Miss Austin	Miss C. A. Lloyd-Roe *1 month*
House Surgeon to Mr. Walker-Brash, Mr. Glasspool	Mr. N. D. Slater to 14.2.78
House Physician to Dr. Southwell, Dr. Williams and Dr. Wharton	Mr. A. P. Plumb to 14.2.78 Mr. B. Mendes Da Costa *6 months*

PEMBURY HOSPITAL

House Surgeons	Miss A. Manktelow *1 month* Mr. J. E. W. Van De Pette to 14.2.78
House Physicians	Mr. K. A. Collett to 14.2.78 Mr. A. R. B. Harris to 14.2.78 Mrs. J. S. M. Tidman *6 months*

ST. HELEN'S HOSPITAL—HASTINGS

House Physician	Mr. T. M. Baylis to 14.2.78 Mr. A. P. J. MacDonald *6 months*

ST. NICHOLAS' HOSPITAL—PLUMSTEAD

House Physician to Dr. Scott	Miss B. A. B. McEvedy *1 month*

GREENWICH DISTRICT HOSPITAL

House Physician to Dr. Hartley and Dr. Thomson	Mr. D. Kipling to 14.2.78 Miss S. G. Overal *5 months*
House Physician to Dr. Mallinson and Dr. Blower	Mr. C. A. Holden to 14.2.78
House Physician to Dr. Colover and Dr. Marsden	Mrs. S. A. Hobson to 14.2.78
House Physician to Dr. Mallinson	Mr. N. S. Nicholas *5 months*
House Surgeon to Mr. Williams, Mr. Park for 3 months and 3 months with Mr. Stoker and Mr. Harrison	Miss C. P. Cavanagh to 14.2.78 Mr. R. Senior to 14.2.78 Mr. J. F. Rivett *7 months* Miss B. A. B. McEvedy *7 months*
House Surgeon to Mr. O'Flynn, Mr. Wilson and Mrs. Wengraf	Mr. R. H. Moore *5 months*

ASHFORD HOSPITAL, KENT

House Surgeon	Miss S. G. Mitton to 14.2.78

HITHER GREEN HOSPITAL

House Physician in General Medicine and Infectious Diseases	Miss N. K. Scott to 14.2.78 Mr. B. A. Price *7 months*

LEWISHAM HOSPITAL

House Physician to Dr. Price	Mr. J. C. Kingswood *7 months*
House Physician to Dr. Stott	Mr. D. V. Rajaratnam *7 months*
House Physician to Dr. Staffurth	Mr. C. S. Bull to 14.2.78
House Physician to Dr. Llewellyn-Smith	Miss J. Glover to 14.2.78
House Surgeon to Mr. Lynn Evans	Miss V. Pain *5 months*
House Surgeon to Mr. Ivo Smith	Miss M. E. Heber *7 months*
House Surgeon to Mr. Monty	Mr. J. B. Warren *7 months*
House Surgeon to Mr. Le Brun	Mr. P. W. Timms to 14.2.78
House Surgeon to Mr. Negus	Miss H. M. Earl to 14.2.78

ORPINGTON HOSPITAL

House Surgeon to Mr. Wilding and Mr. Lam	Mr. R. G. Evered to 14.2.78 Mr. G. Sengupta *5 months*
House Surgeon to Mr. Walker-Brash and Mr. Ratnesar	Mr. V. G. Thornton *5 months*
House Surgeon to Mr. Boxall and Miss Austin	Mr. D. C. Markwell *7 months*
House Surgeon to Mr. Walker-Brash, Mr. Glasspool	Mr. N. D. Slater to 14.2.78
House Physician to Dr. Southwell, Dr. Williams and Dr. Wharton	Mr. A. P. Plumb to 14.2.78 Mr. B. Mendes Da Costa *5 months*

PEMBURY HOSPITAL

House Surgeons	Mr. J. E. W. Van De Pette to 14.2.78 Mr. J. J. McCarthy *7 months*
House Physicians	Mr. K. A. Collett to 14.2.78 Mr. A. R. B. Harris to 14.2.78 Mrs. J. S. M. Tidman *5 months*

ST. HELEN'S HOSPITAL—HASTINGS

House Physician	Mr. T. M. Baylis to 14.2.78 Mr. A. P. J. MacDonald *5 months*

ST. NICHOLAS' HOSPITAL—PLUMSTEAD

House Physician to Dr. Scott	Mr. M. L. Moss *7 months*

EDGWARE GENERAL HOSPITAL

House Surgeon to Mr. Qureshi	Mr. A. D. Bundock *7 months*

DISTRICT GENERAL HOSPITAL, EASTBOURNE

House Physician to Dr. Macleod	Mr. M. A. James *7 months*

MARRIAGES

André John Hedger and Kathleen Claire McDonald married quietly at Lewisham on Saturday, 11th March.

ENGAGEMENT

The engagement is announced between Dr. Jonathan E. M. Fox (H.M.S. Renown, BFPO Ships) and Dr. Judith A. Wright.

BIRTHS

KINDER—To Susan and Richard on 20th February, 1978, at Southmead, Bristol, a daughter, Emily Jane.

CHANGES OF ADDRESS

Mr. and Mrs. J. A. Martin, 21 Cassland Road, Hackney, London, E.9. Tel. 01-986 9557.

Mr. and Mrs. J. Maynard, 14 Blackheath Park, Blackheath, London, S.E.3. Tel. 01-852 6766.

Dr. Jack and Dorothy Palmer (née Hunt), Stanbridges Farm, Handcross, West Sussex. Tel. Haywards Heath 400432.

We should like to remind our readers that all copy for inclusion in the "Gazette" must be received 12 days before publication. Copy dates for the next 3 months are: 17th April, 15th May, 12th June.

Copy may be sent to us at 16, St. Thomas Street, S.E.1.

Birth, Marriage, Death and Change of Address notices are inserted without charge to subscribers.

When subscribers notify the "Gazette" of Change of Address, would they please indicate whether or not this should be published.

Personal notices are charged at 10p per word (pre-paid, minimum £2.00).

Non-subscribers are charged £2.00 (pre-paid) for all notices other than Death.

GUY'S HOSPITAL GAZETTE

ISSN : 0017-5870 Tel. No.: 01-407 7600 Ext. 2023

EDITOR ADRIAN PINI
ASSISTANT EDITOR PHILIP RAZZELL
NEWS EDITORS STEPHEN FENNY and CAMILLA HAW
SPORTS CORRESPONDENT JONATHAN EARNSHAW
NURSING CORRESPONDENT P. M. JEFFERIES
PHYSIOTHERAPY CORRESPONDENT R. J. COOPER
RADIOGRAPHY CORRESPONDENT J. GUEST
MANAGER L. PAYNE

MONTHLY 29 APRIL 1978 VOLUME 93 92 NUMBER 2281

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

Imagine my surprise when, scouring the gutterpress for even better scandal to bring you, I found an article titled "Doctors on Rampage" in a scurrilous rag called Reveille. Their masterpiece had been culled from Richard Johns' heartbreaking soliloquy on the state of the bar (February *Gazette*) and referred to our medics as a bunch of "beer stealing vandals". No mention was made of the dentists from which it seems fair to infer that they must be sacrosanct, teetotal, or extinct.

But how pleasant it is to see such a renowned Fleet Street journal as Reveille making a sensationalist headline out of such a parochial problem. If only Christianity could spread from the parishes like journalese spreads from the editor's desk then we would be a proselytized lot for sure. Reveille's one and a half million readers would do better to take David Denning's masterful (and only) comment that, "We have a small internal problem which is being dealt with." If ever there was a case of passing from unwarranted assumptions to foregone conclusions then this is it. It was claimed that the new generation of doctors are not to be trusted on the grounds that they are responsible for the bar losses but this is like saying that those who buy British Leyland cars are responsible for the financial problems and strikes of that organisation.

Members of the medical profession are easy meat for scandal mongering, just as they are when it comes to the political matters of pay and conditions of contracts and it seems a pity that while we try to uphold high standards others can make such easy profit. By and large the public reads and believes what it wants to and I wonder how long it will continue to put up with such second rate drivel. This is not the first time that material has been taken from the *Gazette* and used for an ulterior motive and I do not expect it will be the last.

NEWS IN BRIEF

Professor Sydney Cohen

Sydney Cohen, CBE, Professor of Chemical Pathology at Guy's and distinguished for his work on the metabolism and structure of immunoglobulins, and on immunity to malaria which opens the way to vaccination against this disease, has been elected F.R.S. We would like to take this opportunity to offer him our warmest congratulations.

Professor M. N. Naylor

Professor M. N. Naylor recently delivered the 1978 Medal Lecture of the Society of Cosmetic Chemists of Great Britain on the subject, "Dental Health—a Community Responsibility" at the Royal Society of Arts, London, and after the conclusion of his lecture was presented with the Silver Medal of the Society by its President, Mr. K. V. Curry.

Medicine Through the Artist's Eye

The Science Museum is currently accepting on long term loan objects from medical history from the Wellcome Trustees, these being part of a large collection of pictures, drawings and engravings in the postgraduate library of the Wellcome Institute for the History of Medicine. They show a fascinating range of human ills and their treatment and should prove interesting to the specialist and ordinary visitor alike.

The illustrations are on view in Gallery 20 for a further week. The museum hours are Monday to Saturday, 10.00 - 18.00 and on Sunday, 14.30 - 18.00. Any enquiries should be made to the Press and Information Officer, Miss Emma St. John-Smith on 01-589 3456, Extension 632.

Guy's Hospital Physiotherapy and Radiography Association

The 1978 Meeting will take place on Saturday, May 13th in the Tower Block, Guy's Hospital.

12.00 for 12.30 p.m. Sherry and a Buffet Lunch in the ROBENS SUITE.

1.45 p.m. Symposium in the Tower Lecture Theatre.

"Bone-scanning in minor fractures"—Dr. A. J. W. HILSON, MB, MSC, MRCP.

"Overuse injuries"—Dr. J. G. P. WILLIAMS, FRCS(Ed), DPhys, Med

"Sports Physiotherapy"—Mr. D. GATHERER, MSCP, SRP, MBAcA

4.00 p.m. Tea.

4.30 p.m. Annual General Meeting.

Cost £1.50—numbers limited to 150.

Please write to:—

Hon. Secretary,
Miss J. C. McK. Simmons,
G.H.P.R.A.,
Shepherd's House,
Guy's Hospital,
London, SE1 9RT.

Area Health Cuts Report

Much has been made recently of proposed health spending cuts in the Lambeth, Lewisham and Southwark Area Health Authority, to which Guy's Hospital belongs. Some of the thinking behind these cutbacks can be found in the "Planning Guidelines and Policies" booklet published by the S.E. Thames Regional Health Authority, which sets out the proposed strategic resource allocations for the region in the coming decade.

Each Area within the region has or will receive a figure representing the projected resource allocation for 1986 on which to base programmes of capital expenditure in the coming years. The Region in which our Area Health Authority is situated inherited many problems on its formation—many associated with previous hospital building policies, which resulted in, among other things, an over-provision of dental services in central London and a shortage of mental illness and handicap facilities. It has twice the national average ratio of undergraduate teaching hospital beds (15% compared to 7.4%) and there is increasing indication that the population within easy reach of its three teaching hospitals (Guy's, St. Thomas' and King's) may be insufficient to provide the clinical material needed to train students.

While Guy's part of the Region is well off in relative terms other parts of the Region are comparatively deprived. The South Coast and Medway towns, for example, have a severe shortage of health care facilities—a fact well known to the Resource Allocation Working Party (RAWP) on whose guidelines and formulation the Region's forecasts are based.

Our Regional Health Authority in determining its future resource allocations aims to correct these imbalances and to achieve a "more equitable distribution of resources". The effects on Guy's and its neighbouring teaching hospitals remains to be seen.

Draft "Planning Guidelines and Policies", S.E.T.R.H.A., January 1978.

General Practitioner Meetings

The following meetings will be held at Guy's on the first Wednesday of each month in the Demonstration Room, Dept. of Neurology, Ground Floor, Hunts House at 8.15 p.m. (Coffee and sandwiches available from 7.45 p.m., and facilities are available for doctors to receive phone calls.)

Wednesday, 3rd May—Prostate problems—*Mr. M. Joyce.*

Wednesday, 7th June—Talk and discussion on the place of brief psychotherapy in General Practice—*Dr. J. Fry.*

Wednesday, 5th July—Subarachnoid Haemorrhage—*Mr. C. Polkey.*

Three more meetings will be held at New Cross Hospital on the first Tuesday of each month in the Nurses Lecture Room commencing at 12.30 p.m. with a buffet lunch.

Tuesday, 2nd May—Hypothermia in the Elderly—*Dr. M. F. Green.*

Tuesday, 6th June—Non-invasive assessment of transient ischaemic attacks —*Dr. R. R. Lewis.*

Tuesday, 4th July—Laboratory findings in the elderly—*Dr. H. M. Hodkinson.*

Tower Restaurant Opening Times at Night

The Tower Restaurant now opens at the following times:—

8.30 p.m.– 9.30 p.m.	Breakfast.
9.30 p.m.–11.00 p.m.	Light Meal.
12.00 p.m.– 2.15 a.m.	Midnight Meal.
3.00 a.m.– 5.00 a.m.	Beverages.

Prizewinners

The following prizes have been awarded.

Gowland-Hopkins Prize in Biochemistry, February 1978—I. G. Kestin.

Charles Forster Prize in Cardiology, February 1978—Prize not awarded.
Certificates of Merit—R. M. Atkins.
Mrs. A. Holden.

Treasurers Medal and Prize in Clinical Medicine and The Baldwin Clinical Prize, March 1978.
Medal and Prizes—T. J. Palmer.
2nd Prize—Miss S. A. Amiel.

Charles Oldham Prize in Ophthalmology, 1978—Prize not awarded.

Ian Howat Memorial Prizes, 1978.
—T. G. K. Monk.
D. F. Maxted.

Drapers Company Awards, 1978.
—Mrs. J. R. Potter.
Mr. M. C. Wake.

School Prize in Pharmacology, 1978.
Awarded jointly—N. A. Fletcher.
I. G. Kestin.

Dates from the Dental Diary

Friday, 28th April—Applications close for the Second B.D.S. (July) Examination.

Monday, 1st May—BANK HOLIDAY—Medical School Office closed.

Monday, 15th May—Final L.D.S. Examination, Part 1 begins.

Friday, 19th May—Entries close for the David Frank Sturdee Prize in Prosthetic Dentistry and the properties of Dental Materials.

Monday, 22nd May—First L.D.S. Examination begins.

Monday, 29th May—BANK HOLIDAY—Medical School Office closed.

Dates from the Medical Diary

Friday, 28th April—Entries close for the M.B., B.S. (Revised Regulations) Examinations in June.
Entries close for the Leslie Hillman Prize in Haematology.
Schedules for the Final Conjoint Examination must be left in the Medical School Office by this date.

Monday, 1st May—BANK HOLIDAY—Medical School Office closed.

Michael Harris Prize in Anatomy, February 1978.
Prize—N. A. Fletcher.
Certificates of Merit—D. J. Bailey.
D. E. Fish.
T. D. Houlding.

Wooldridge Prize in Physiology, February 1978—Prize not awarded.

Dermatology Firm Prize, January and March 1978.
1st Prize—C. J. R. Parker.
2nd Prize—I. D. Gold.

After paying you £2,636 a year as a student, the last thing we'll give you is a dull job.

The Royal Navy is looking for a few, a very few, Naval Dental Cadets.

If you have a 2nd BDS (or equivalent), and you can pass our interview board, we will pay you £2,636 a year as a student.

And on qualifying, you'll start a 5-year Short Service Commission as a Dental Officer.

To tell you in advance exactly how you would spend your 5 years is one thing we can't do.

Because we try to keep the system as flexible as possible, to fit in with our needs and your own wishes.

But we can give you an idea of some of the opportunities. You could spend two years in a ship at sea, which is equipped with a surgery with all the equipment that you'd find on shore.

Or you could spend a series of short periods moving from one ship to another.

In that case, you might well expect to be winched from ship to ship by helicopter.

And you'd have with you a complete, portable dental surgery.

Part of your time, you'll certainly spend on shore. (In fact, one of our Dental Officers has chosen to spend the whole 5 years on shore.)

So you might have a couple of years at a Naval establishment, which could be a training establishment, where you'll be treating young sailors. Or a NATO base, where you'll be looking after anyone from ratings to admirals. We also have a flying squad, all volunteers, mostly young and unmarried.

They're ready to down drills at any moment and take off for a spell at a different Naval shore base or in a ship wherever she may be.

The principle is that we take dentistry to the patient. You don't have to wait for him to come to you.

And, basically, your job is to see that the Royal Navy's sailors and officers are fit enough to do their job. Given that, you'll have the same clinical freedom, the same equipment and the same materials as you'd find on shore.

The dentistry, however, is only part of the job.

You'll also be a Naval Officer.

When you're at sea, you'll be part of the team of Officers who are responsible for running every aspect of the ship.

You'll be able to enjoy the sports and social facilities which the Royal Navy offers.

Which leaves the question of pay.

Immediately after you qualify, your salary will be £6,517.

And at the end of your 5-year Commission, you'll leave with a gratuity.

Or you can apply for a Full Career Commission or a 16-year pensionable Commission.

If you'd like to know more, write giving details of your age and qualifications to: **Surgeon Captain (D) F.R.B. Mathias, RN, (26GS), Room 314, Empress State Building, Fulham, London SW6 1TR.**

Wednesday, 3rd May—Examination for the Leslie Hillman Prize in Haematology begins.

Monday, 29th May—BANK HOLIDAY—Medical School Office closed.

Tuesday, 30th May—Entries close for the Final Conjoint Examination in June.

"Gazette" New Appointments

The editorial staff are joined this month by Camilla Haw, B.A. as News Editor and Jonathan Earnshaw as Sports Correspondent. Camilla came to Guy's from Cambridge to restore some equality of the sexes, while Jonathan takes over from our last sportsman Gus Kingon. We are also pleased to announce the appointment of Dai Fliedermaus, a man with a bright future behind him, as honorary Welsh correspondent. Our man in Cardiff is somewhat on his own and so we invite applications from those who feel sufficiently patriotic (nationalists excluded) who wish to join him in what might be his last career. We wish them all the very best of luck and a happy association with the *Gazette*.

NOTICES

Service for Miss Emily E. P. MacManus

A Service of Holy Communion in thanksgiving for the life and work of Miss Emily E. P. MacManus, C.B.E. will be held in the Hospital Chapel on Wednesday, 10th May, 1978 at 11 a.m. As many will wish to come to this service there will be extra seating in the East Wing Ballroom to which the service will be relayed.

Guy's Hospital Biennial Dinner

The next Biennial Dinner will be held in the Connaught Rooms, Great Queen Street, Kingsway, W.C.2 on Friday, 6th October, 1978. All qualified Guy's men and women, medical and dental, are invited to attend, so please make a note of this date. Further details will be made known by circular and in the July issue of the Gazette.

Blues Committee

The Blues Committee will be meeting on Friday, 26th May, at 530 p.m. in Boland House to consider new awards. Captains of all the Athletic Clubs should send their nominations for Full and Half Blues to the Committee Secretary by Friday, 21st May.

M. C. E. Hutchinson,
Hon. Sec., Blues Committee,
Guy's Hospital Medical School.

CLUBS' UNION NEWS

The Changes to the Constitution

You cannot fail to have noticed in the last issue of the *Gazette*, the correspondence concerning the changes proposed to the constitution. The time must now have come to talk about these and their implications.

It is the Clubs' Union's job to (1) organise sporting, social and cultural activities for its members; (2) provide for the representation of the views of the medical and dental students; and (3) generally to foster the interests of its members.

The difficulties are most notable with the second of its roles, that of representing students' views. What are students' views? Do students have views? Should attempts be made to understand and assess their views? In the present constitutional framework there are (or should be) three General Meetings a year. Anybody can send any item for discussion at one such meeting to the Senior Secretary a week in advance. This gives any individual the capability of raising any issue he feels ought to be discussed. Ten per cent of the students constitute a quorum at General Meetings.

Those who have been involved in the Clubs' Union over the past couple of years have perceived a general lack of interest in General Meetings. A few have been inquorate, and many bordering on inquorate. There has been little attempt at these meetings to assess student opinion on topics of concern, although there are two notable exceptions to this; the debate on N.U.S. (resolved by a referendum, *not* a General Meeting) and in Peter Watkinson's time the discussions concerning the possible installation of a contraceptive vending machine in the gentlemen's toilet (I understand the discussion centred on whether it should be installed in the gentlemen's or ladies' toilet!). It was in the knowledge that so little had been discussed that the proposal for change arose. General Meetings are a poor way of encouraging or even allowing students to air their views and certainly a consensus of views has rarely been reached.

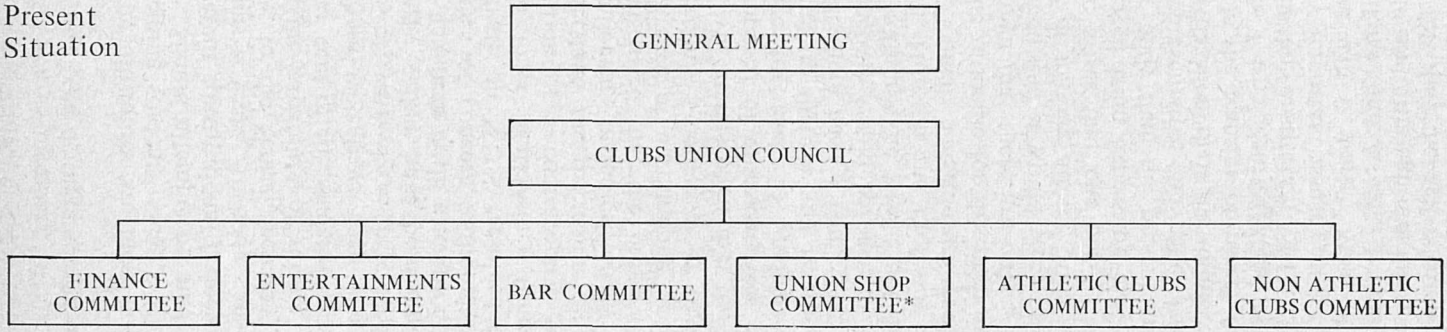
It was at this point that the idea of a General Council arose. It would be composed of representatives elected by each academic year, one representative for each 25 students and the present Clubs' Union Council. Totalling up there would be about sixty members of this General Council each of whom have a vote. They would be able to be re-elected each year. The meetings would be open to any student if he would like to attend and speak, although he would not be able to vote on any issue. In addition both Dr. Houston and Professor Emslie would be asked to be full members of the Council. The quorum would be forty.

The rationale for this proposal is quite straightforward. Past experience has shown that there are only a few individuals interested in the affairs of the Union and it would seem sensible to give those individuals the responsibility of making all the decisions concerning the Union. However, when a topic arises that one person is particularly interested in, that person is not barred from expressing his opinion. Power would be transferred to a smaller body than the present impotent General Meeting, but that body is both representative and better informed and is likely to make a more considered decision than the uninformed individual at a General Meeting. (In principle the transfer of power from the populace to a body of experts is not one I wholeheartedly endorse and for that reason provision would be made in the constitution for Extraordinary General Meetings and referendum on very important issues.

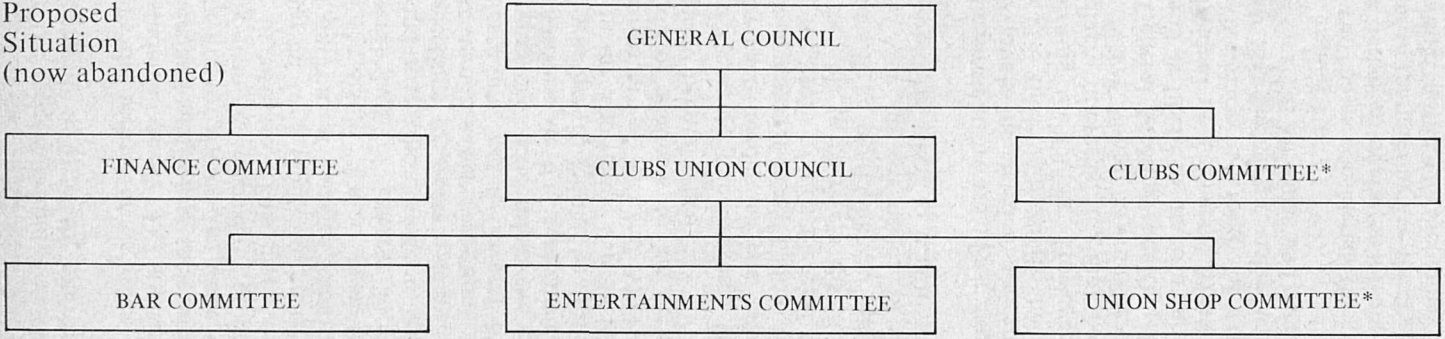
But will it work? Most of those who have considered this idea in depth don't think it will. It demands the active co-operation of about fifty students, and although it would not meet more than about five times annually it was felt that the active co-operation would not be forthcoming. So for

Diagram showing the structure of the Union and how the changes proposed would change it.

Present Situation



Proposed Situation (now abandoned)



*The Book Exchange will be replaced by a Union Shop and it has been suggested that all the Constituent Clubs' should be joined under one committee the Club's Committee.

the moment the idea has been dropped. There are considerable ramifications to this proposal which merit consideration alone and some of the other proposals put forward are still awaiting further consideration.

There are, however, some recommendations that will go forward directly to the General Meeting. Instead of one Vice-President and an ordinary member, it is suggested that there should be two Vice-Presidents, one medical and one dental. They would carry joint responsibility for external affairs each with a bias towards medical or dental education. Each would also, with the prior approval of these bodies, sit on the Student Medical Education Committee (S.M.E.C.) and the Management Committee of the Dental Society respectively. (The Dental Society has in fact already approved this.) It has also been suggested that all three sit on School Council and if the President was a dentist both himself and the dental Vice-President on Dental Council.

In June the sub-committee will get together again and reconsider some of the proposals put forward. The general lack of faith in the concept of a General Council (a lack of faith I can readily understand having come up against the typical "not very active" student frequently) has meant that a considerable rethink is required. You will be kept fully informed, as usual.

THE CONTINUING SAGA OF THE BAR

During the last few months the bar has been the subject of several articles, including what I would call a smutty piece of scandalmongering in a weekly newspaper. This sudden interest in our lower ground den of iniquity has without doubt been provoked by the large and seemingly increasing amounts of money that have suddenly and inexplicably started to disappear from the establishment. Although these articles have all contained various facts and figures I could not really say that I think any of them have presented the full picture and so I have decided to try and convey exactly what is happening in the bar.

The turnover of the bar is about £60,000 per year of which about £4,000 should be net profit. The bar accounts are presented to the Bar Committee monthly and these figures have always fluctuated between the limits of an excess of £100 per month and a shortage of £200. Shortage in this context does not mean a net loss but merely a loss of the expected profit, a shortage in the order of £200 per month is therefore acceptable despite being highly undesirable.

However, towards the end of last year these shortages suddenly escalated from £70 in August and £200 in September to £1,000 in October —a staggering change. Since then the figures have remained steady at a shortage of between £700 and £900 per month. These shortages are clearly not acceptable but they were nevertheless absorbed by the expected profit margin and no net loss was incurred. No net loss that is, until January which showed a shortage of £880, representing a net loss of £240. This was therefore the first month that the bar did not remain solvent. Beyond that I cannot report since we have not received the February figures yet. These losses are of course very worrying and one would think that, with such large sums being involved it would be easy to discover the source. However, we have been unable to find out where the money is going—and that is not for want of trying I can assure you!

What is being done about the situation?

At first it was suggested that free drinks—i.e. "Guy's Halves" may be accounting for a substantial proportion of our losses and so the infamous "Measured Half" pump system was installed. Unfortunately, as most of you are probably well aware, the system has never worked properly from the day it was installed and I, for one, feel that January's disastrous figures (the first after the pumps were installed) were due, at least in part, to the appalling wastage of beer caused by the new pumps—a wastage which, ironically, must have greatly exceeded the amount of beer lost in Guy's Halves. The cost of these electrical wonders would be £1,150 but, in view of the fact that they have never worked properly this has not been paid. Following our continual trouble with the pumps, Gaskell & Chambers (the firm who installed them) have added five new motorised pumps to the system, at no extra cost, in order to increase the pumping power, but whilst these have improved matters considerably we are still suffering from a steady stream of problems and it will be interesting to see how this is reflected in the figures for the months after January. After a continued barrage of moans and groans from myself and other student members of the Bar Committee who use the electrical abominations, the committee have agreed that if a drastic improvement is not seen from the abominations within the next month we will have to consider replacing them, making the original installation an expensive mistake by any standards.

So much for electric beer. Considerable suspicion has fallen on the bar staff in this matter and although this suspicion has no basis of evidence that I know of, it was decided to reduce the numbers of bar staff to a bare minimum to increase security. Therefore, without pointing any suspicion whatsoever at them, I dismissed about thirty members of the bar staff leaving about thirty-five. These people are all in my opinion reliable and hard working but nevertheless people continue to cast aspersions on their integrity —an attitude I find highly insulting since these accusations seem to be made without any grounds whatsoever. I would therefore suggest that these people do not come to me with their sweeping statements until they have some hard evidence.

It has also been suggested that our losses could be due to stock being stolen before it ever reaches the bar itself and we have therefore tried to tighten up on the bar's security. These measures have included various locks bing changed, the alarm system being improved and new locks fitted to all the windows.

Unfortunately, before all this was done the bar was burgled, early in March and although this event has now lapsed into the realms of "old news" I have been asked to give an account of what happened in order to answer any questions remaining in anyone's mind. The miscreants responsible for this desecration of our underground shrine entered the building through an unlocked window and got behind the bar by knocking out a panel in the false ceiling, crawling through the ceiling recess, over the top of the shutters and then knocking out a second ceiling panel *before* dropping down into the bar area. Having made their somewhat ingenious entry they then smashed the shutters anyway! Their "swag" included about £70 in loose change from the football machines which was locked in a cupboard rather than the safe. They also drank half a bottle of scotch, smashed the optic and then turned their attentions to the tills which they almost wrecked while trying to get them open when all that was necessary was to press the button! They failed

to open either of the empty tills. The carnage almost complete they then proceeded to defaecate on the floor, performed their ablutions and made good their getaway, taking with them our entire stock of cigarettes which was later found scattered around in the road outside. Thus, our losses in terms of cash and stock were very small but unfortunately the brunt of this somewhat bizarre break-in was borne in the repair bill for the tills, which will be in excess of £400 while the bill for the repair of the shutters will come on top of that. This could, perhaps, all have been avoided if the alarms had been set that night as they would have gone off when the shutters were smashed. Unfortunately although they were in working order that night the alarms had been going wrong so often that the bar staff did not set them on that particular occasion. We hope that the recess above the false ceiling can be blocked in some way to prevent this from happening again.

Nearing the end of this somewhat lengthy article I would like to draw readers' attention to the facts that we have changed the Carling lager to Tuborg and Sam Smith's strong pale ale is now available. I am also pleased to report that in future the bar will remain open until 11.00 p.m. on inflam nights.

Finally I would like to appeal to all students in Guy's to come to me with any suggestions that they feel might improve the bar. I can only request changes and improvements from the Bar Committee if I know what you want. I will be pleased to see anyone anytime.

Neil Mathews, Bar Secretary.

Review

U.L.U. Gilbert & Sullivan Society

THE SORCERER

15th–18th March, 1978

"The Sorcerer" was performed by the University of London Opera Groups and Gilbert and Sullivan's Societies at Manning Hall to the obvious enjoyment of both participants and observers. Credit must go to Adam Skinner, from Guy's, for his excellent, and highly amusing performance of Alexis, which met with a delighted response from the audience.

For those unacquainted with "The Sorcerer", it tells a tale not unlike that of Shakespeare's "A Midsummer Night's Dream", with a sorcerer's potion making some, to say the least, unusual matches between folk of a small country village. All this, needless to say, at the inspiration of Alexis, who, being in love with Aline, wishes all the village to be as happy as himself.

Aline, played by Sue Kingston (who produced "H.M.S. Pinafore" last term), gave a highly commendable performance, as did Peter Crockford, who took the part of the Sorcerer. In fact, it would be hard to criticise the choice of any principal, so convincingly did they portray their roles. Costumes and scenery added to the bright atmosphere of the evening. The costumes in particular were aptly chosen to identify with the character in question, and left one in no doubt that Gilbert and Sullivan intended "The Sorcerer" to be a far from serious venture!

In all, an enjoyable evening, and musically, a very proficient performance. Congratulations to the orchestra who managed to achieve that rare balance whereby one could hear both instruments and voices together! Guy's G. & S. take note.

J. W.

QUODLIBET SOCIETY

Peter Webb on "Art and Pornography"

Thursday, 9th March 1978

Peter Webb, art historian, and presently a lecturer at Middlesex Polytechnic, had a full house for his talk on "Art and Pornography". The audience remained attentive throughout, reflecting the subject's great interest.

Webb began by examining the distinction between pornography, with its sole intent to excite one sexually and eroticism, with its more sustained and wider appeal. He then went on to discuss the role of censorship in our society and the various discrepancies that exist. A piece of abstract sculpture was deemed, "an indecent implement" and refused entry to the U.S., yet few have protested about the blatant and provocative advertising which constantly surrounds us. Webb felt that by and large censorship was wrong and that pornography performed a definite function. It enabled shy, repressed and inadequate adults to indulge in escapism. However, he did express reservations over the use of children, although as he so rightly pointed out this is not a new phenomenon. The Victorians condoned the existence of child brothels and paedophilic literature widely circulated amongst the upper classes.

Attitudes towards sexual imagery vary considerably from culture to culture and also with the passage of time. Webb clearly demonstrated this by showing examples of art from the ancient civilisations. The Greeks, Romans, Pre-Columbian Incas and Indians all had an open attitude towards sex and saw it as a vital part of life. Their images reflect this by their shame-free, refreshing nudity. However, by Renaissance times, the consensus of opinion had changed as Michaelangelo discovered. When his sculpture of David went on exhibition the artist was enraged to find a stone fig leaf had been added in the interest of public decency. His male portraits on the ceiling of the Sistine Chapel met with a similar fate. The authorities employed a team of painters to "clean them up" once Michaelangelo had completed his work.

Artists may have been thwarted from displaying their erotic art to the public but this in no way prevented them from creating it. Goya, Rowlandson, Fuseli, Turner and Beardsley, to name but a few, were prolific in this direction. After Turner's death Ruskin sought to protect his friend's reputation by destroying most of his sensual pictures. This story is all too familiar. Of the works that remain many are entombed in the secret collections of our national museums, considered fit only for the eyes of a chosen few experts. The British Museum even has a clandestine tray of marble penes, chipped from classical sculptures by 19th century archaeologists. Perhaps the message is, we, the general public, are being deprived of seeing a great wealth of good erotic art. Should we be so accepting of this denial?

Quodlibet Summer Programme

Tuesday, May 9th

Arthur Scargill, President of Yorkshire N.U.M. "The man who tried and failed to get the miners £135 per week"—Christian and Marxist.

Speaks on the topic of his choice (to be advertised later)—at least half the meeting will be devoted to what is hoped to be lively discussion on his views.

5.30 p.m. tea.

5.15 p.m. sharp—meeting starts.

Anatomy Theatre, Medical School.

Thursday, May 18th

John Pardoe, Liberal Party No. 2, spokesman on economic affairs and "adviser" to D. Healey during the Lib-Lab pact. Talks on

"Can we do without a prices and incomes policy?"

The Tories think that we can, Callaghan and Healey think that we can't—We have had it almost continually over the last five years, is it the only way to beat inflation? This is clearly the issue to make or break the next (autumn?) election.

5.30 p.m. tea.

5.15 p.m. sharp—meeting starts, there will be plenty of time for discussion.

Tower Theatre, 30th floor.

Tuesday, June 20th

Debate. "Do we need censorship?"

This debate follows on very much from Peter Webb's presentation last term on Pornography and Art, where he presented the thesis that for adults at least sexual censorship was a relatively modern concept, and was harmful to the society.

There will be two guest speakers and two Guy's speakers so that there will be *plenty* of time on this occasion for a very full floor debate (will send details of speakers as soon as possible).

Tuppy Owens, dynamic editor of the *Sex Maniac's Diary* and well-known porno supporter, will be speaking.

5.30 p.m. tea.

5.45 p.m. sharp—debate starts.

Tower Theatre, 30th floor.

Two Guy's speakers will be needed to make formal speeches—could they make their applications to do so before May 15th.

General

This is a society run by medical students, but anyone working in the hospital is most welcome to come and to participate. If anyone would like to meet any of the speakers for drinks after the meeting (before dinner) it is usually quite easily arranged provided that a message is left for me in the Quodlibet in-tray. Quodlibet was started by Sir John Coneybeare in 1959 to "ensure that students of the hospital should take an active interest in the affairs and happenings of the outside world". We try, therefore, within this brief to give people "what is desired", but can only do so provided that we get feedback as to what is desired.

MISS EMILY ELVIRA MacMANUS, C.B.E.

We should like to state that Miss MacManus' name should have appeared as above in her obituary in last month's Gazette and should of course read with the C.B.E.

SOUTH WALES AND MONMOUTHSHIRE GUY'S SOCIETY

Annual Dinner 1978

Those of you who are familiar with all of Cardiff celebrating a victorious Welsh XV will have some measure of the welcome we received. Fighting our way past the open doors of pubs and churches (which looked as if they couldn't close) we arrived decorous and soberly dressed at the Park Hotel. The President, Mr. Reggie Hoar, began proceedings with a formal welcome to the dinner, wine, anecdotes and reminiscences.

Left to right: *Mr. Arthur Davies, Dr. Anthony Thomas, Mr. Morwent Brown, Dr. Harry Freeman, Mr. Hugh Harley, Professor A. Rowe, Mr. Reggie Hoar (President), Mr. Noel Glover, Dr. Leonard Emery, Mr. Graham Davies, Dr. Howell Jones, Mr. Edward James.*

Mr. Glover, the first guest speaker, gave an amusing commentary of the developments at Guy's, both in facilities and attitudes and conveyed personal messages from the many departments of the hospital. Professor Rowe then continued the evening with a humorous discourse on the rise of Guy's Tower—with the aid of projections. Contrasting old and new, Professor Rowe showed slides of students in the Dental School of 1900 to be greeted from the floor by "Friends of yours Jack?" Then to uproarious applause the recently qualified Dr. Harry Freeman rose to laud the "quint-

essence of oration" which he had heard from the floor. Far from laconic, he outlined his own student selection procedure which would ensure the admission of a "better class of creep" to Guy's.

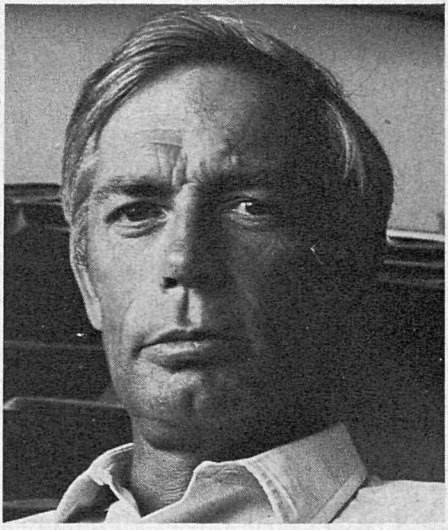
Encouraged to reply, Mr. Glover wittily conceded that when it came to student affairs Dr. Freeman is somewhat of an expert, having arrived five years before Mr. Glover, and qualifying five years after him!

We should like to thank the Society for their generous hospitality; long may festivities and societies like this continue—a most memorable evening.

Our Welsh correspondent, Dai Fliedermaus.

Appreciations

PROFESSOR JEFFREY W. OSBORN



Late this Spring the Unit for Anatomy in Relation to Dentistry (and hence the Department of Anatomy and the Medical and Dental Schools) will lose to an overseas school a man who, as student (1951-55), house surgeon and part-time demonstrator in special dental anatomy (1956-64), and finally as a full-time, professional "dental" anatomist (1964-78), has worked in our community for 27 years. Such is the length of the roots which professor Jeffrey Whitaker Osborn has put down in Southwark; and one may well ask why he should now uproot himself and transplant himself and his family to an alien clime, place and culture. But that is another story, and one for him to tell.

As a student he entered with a Confined Scholarship in Science and later earned distinction in Special Anatomy and Physiology, becoming a student demonstrator in 1952—an omen of his future career. Having qualified in 1955, he gravitated towards part-time clinical practice—but he retained a foot in the academic door as part-time demonstrator in dental anatomy (1957–64). Although he proceeded to a higher qualification (F.D.S., 1960), he was already moving towards research and teaching. He was appointed as lecturer in 1964 in the newly-formed Unit based in the Department of Anatomy, whose first "head", Dr. Richard Ten Cate (now Dean of the Dental Faculty, University of Toronto) had been appointed in 1963. It is appropriate to recall that when the writer arrived at Guy's Hospital Medical School in 1955, Professor W. R. Spurrell, then Professor of Physiology, had already established a senior dental post in that department and was equally eager to sponsor a similar development in anatomy. These posts were forerunners to others in the Dental School and their success redounds to the credit of Professor Spurrell.

When Ten Cate left for Toronto in 1968, Jeffrey Osborn succeeded him as director of the Unit. He had already acquired a Ph.D. degree, and he

carried even further the excellent organisation of teaching in special dental anatomy accomplished by Ten Cate, displaying in this a characteristic *élan* and energy. He was joined by Dr. Karen Hiiemae in 1969 and later by Andrew Sita Lumsden, thus forming a sufficiently strong team to intensify teaching without undue effects on research. All three have displayed an excellent balance between the care of their undergraduate students (including some taking an Hons.B.Sc.) and the prosecution of research, in which they have carried the repute of this School to a high level in their own fields of interest.

Professor Osborn and Dr. Hiiemae have developed strong links with Harvard, where the latter has held a part-time Research Fellowship in Biology for many years. In 1971–72 Professor Osborn was invited to Harvard as Visiting Agassiz Professor in Vertebrate Palaeontology, an interest which has dominated his recent research. His earlier papers had been concerned with the structure of dental enamel; but from about 1970 he has turned towards the organisation and evolution of dental patterns, and particularly the problems of the evolutionary transition from reptilian to mammalian forms of dentition. In these and parallel studies Jeffrey Osborn evinces a high ability to fuse mathematical analysis with biological thinking. He has an enviable talent, both in speech and writing, for lucid, succinct and even eloquent disquisition, a talent which many must have witnessed, outside the lecture theatre, in committee meetings. In contrast, he is capable of considerable silences; but, when his interest or concern is sufficiently aroused, the pipe is removed to permit the release of a controlled torrent of words, sometimes nevertheless laconic, always unequivocal, occasionally dogmatic, but never boring. Such verbal facility has been, of course, almost a necessity, for his closest colleague for the last eight years is a most stentorian scientist, and no one could accuse the Department of Anatomy of taciturnity.

I suppose that one must dub Jeffrey Osborn as an intellectual. Except for the occasions when he is encountered on return from perspiratory sessions at squash, he appears to be averse to physical exertion; and it seems that even these episodes are basically therapeutic. I suspect that he is what used to be called a "natural philosopher", and not a magpie scientist amassing data, but rather an intelligence intent on interpretation. Sometimes perhaps his hypothecation over-reaches the factual data; but of one thing I am sure: his factual feet and interpretative head will be chasing each other in and out of balance in Edmonton with the same enthusiasm which I have admired during the whole of the 14 years I have known him. He goes to the Faculty of Dentistry, University of Alberta, as Professor and Chairman of the Department of Oral Biology. We all wish him good luck and happiness, but what a pity that he must go.

Roger Warwick

STEPHANIE A. AMIEL, B.Sc.

Stephanie Amiel is the second woman to have edited the *Gazette*. Being able to write both stylishly, even lavishly, and yet concisely Stephanie is an able person indeed. I well recall the note from a doctor who said that in thirty-five years of reading *Passim* he had enjoyed one of hers the best and I know that many others share that kind of respect for her various contributions.

Stephanie came to Guy's in 1972 and joined the *Gazette* as a News Editor in February 1976 after taking an honours B.Sc. in the Department of

Vintage Stephanie

Pathology. Her first paper was published soon after graduation and like her father she went on to win the Golding Bird Prize in Bacteriology during her clinical studentship as a Confined War Memorial Exhibitioner. Her only pathological contribution to the *Gazette* so far has been the *Neoplastic Placenta!*

The distinction between censorship and editorship is always a fine one and Stephanie has had some difficult decisions to make as those who have followed the correspondence columns recently will know, but equally there have been the many humorous moments in fending off the M.C.P.'s!

Stephanie has worked hard for the Gazette, success and goodwill have deservedly been hers and we can only wish her the best of luck with her finals and future career, although I don't expect she will need much.

RICHARD HENDERSON, B.Sc.

We also say goodbye this month to our assistant editor Richard Henderson. Richard, like Stephanie, came to Guy's in 1972 and after completing an honours B.Sc. in the Department of Anatomy joined the *Gazette* in September 1976 as News Editor. At this time he was awarded the Golding-Bird Scholarship in Bacteriology.

Richard was already known for his "journalistic acumen and grammatical perspicacity" and his standards of accuracy and precision have never been anything less than first rate. Richard's expert and always tactful contributions at the proof reading sessions will be sorely missed. We wish him the very best for his finals and the future which is sure to be a bright one.

A.P.J.P.

THE HOSPITAL CHAPEL

The hospital chapel is this year just 200 years old, and its recent redecoration calls for special mention. There is no record of the decoration of the chapel when it was built in 1770, but many will remember the "Victorian" chocolate, and the texts that adorned the walls, until 1952. In that year the chapel was redecorated through a benefaction under the will

Continued on page 152.

GUY'S (I.L.E.A.) HOSPITAL SCHOOL

By Miss G. I. Maxwell,
Headmistress

We are a constant surprise to people at Guy's. Hospital staff from other departments, parents of new child patients and even new staff on the children's wards often look at us with puzzled expressions. The unspoken question seems to be "Who is this person pushing the laden trolley, down on hands and knees vigorously mopping up spilt paint by someone's bed, sweeping sand off the floor or surrounded by children, typing, cooking or sewing? 'Play worker', 'Occupational therapist', 'Cleaner'?" If the questioner looks more closely and sees the badge all is explained, "Teacher"! Although the children's school at Guy's started in 1949, the first to be established in a London general hospital, many people still do not know of the existence

of schooling for children in hospital. Sadly, even today many hospitals with childpatients are still without children's schools, although it is a legal requirement that children in hospital should receive education appropriate to their age, ability and aptitude. Teaching for the children at Guy's was

started by the then London County Council (now the Inner London Education Committee) at the request of Dr. Evans and Dr. MacKeith. One teacher was appointed for all the children in the old Evelina Hospital and one for all the children at Guy's. It soon became obvious that two teachers were not enough and so their numbers were increased until there were two teachers working at Evelina and four at Guy's (two on the children's and two on the adult wards). Mrs. Macnaughton-Smith became the first Headmistress in charge of the work in both hospitals. It was written into the original constitution of the school that all children over two years of age should be included in it. Mrs. Macnaughton-Smith died very suddenly and Miss Dorothy Roberts succeeded her in July 1955, and remained Headmistress until her retirement in April 1974. During Miss Roberts' time the work of the school expanded with the opening of Hector Cameron Ward, the children's psychiatric unit at Evelina. Miss Julie Miller, who was already on the school staff, became the first teacher on this unit. Miss Barbara Worlidge, the deputy headmistress, who worked on the children's wards at Guy's, became aware of the need for a teacher on the Dialysis Unit, when children began to be admitted to it, and she pioneered the work there. It also became necessary to have a part time teacher in the Bloomfield Clinic to teach children who came in for one or more sessions a week from their own schools for remedial help.

I was appointed headmistress in January 1975 and have seen many changes in the school in that short time. At that time, our only school

premises were a tiny office and staff/store room in the Evelina basement, and an even smaller staff/store room in Hunt's House at Guy's. These rooms were all very grubby and cluttered. Most of our equipment was stored in cupboards in corridors. In October 1975, after many rumours and false alarms, we eventually moved to our long-awaited new premises in Guy's Tower. What an upheaval! The I.L.E.A. supplied us with innumerable tea

chests, but we had the task of filling them. At that time the school had a fortnight's holiday in October and some of us spent most of the "holiday" packing and then unpacking all our equipment. Before the great removal we had visited the Tower several times and were delighted with our new premises. Once we had moved in, however, we discovered all its shortcomings. Our one classroom, which had seemed so spacious empty, is small, over-heated and very over-crowded even with a minimum of furniture and a few children, but we are, nevertheless, delighted to have a room of our own where children's work can be left undisturbed. We also have a stock room, a small AVA store, and a tiny staff/work room on floor 12, and a very small office, ably manned by our two part-time secretaries, on floor 10.

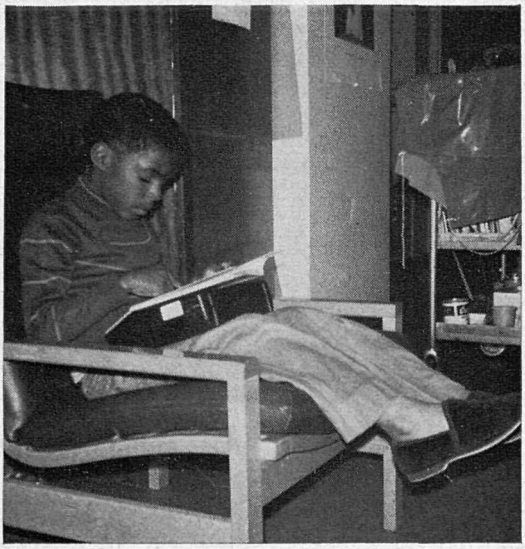
Since the move to the Tower, our staff has gradually increased as we have been able to show that we are teaching more children and as staffing ratios in London schools have improved. At present we have 13 teachers who are distributed as follows: 1 teacher in our classroom on floor 12, 2 teachers on the surgical wards on floor 11, and 1 teacher helped by a nursery assistant (appointed in February 1978) who has a nursery class in the day room on that floor for the children from both wards; 2 teachers on the children's psychiatric ward and 1 teacher on the medical ward on floor 10; 1 teacher on the renal ward, 1 for the children in isolation and 1 working on the dialysis unit, all of whom can interchange; 1 teacher on the adult wards and 2 part-time teachers on Bloomfield Clinic doing remedial work with children who come in for one or more sessions a week from their own schools.

Since September 1976 we have not closed for school holidays. Apart from Bank Holidays and a few days at Christmas when the hospital is very empty, the school remains open five days a week throughout the year, running with a much smaller staff during normal school holidays and operating "holiday school" unless children particularly need (and want) remedial help with basic skills. We believe that the hospital appreciates this and we feel that it is much more satisfactory as there is continuity in our work. To ensure this we work in small teams so that the children and ward staff are familiar with more than one teacher. Each ward has a very individual character and teachers who are in the school for a few years have the opportunity to teach on more than one ward during that time.

As far as possible the older, longer stay children have their schooling in our own classroom on the 12th floor. All our books and equipment are then readily available to them and they can continue with their own school work with as little interruption as possible. Whenever children are to be in hospital for more than a few days we contact their own school direct, usually by telephone, so that the children's schooling here is continued on the same lines as far as possible. The under 5's are then catered for either in our nursery class on 11th floor or by one of the two hospital playworkers on floors 9 and 10. This means that most teachers now have more manageable groups of 5–9 year olds on the wards, where solid work in the basic skills can take place in the mornings (or learning through games for the very short stay children). We are fairly traditional in our approach and deplore the lack of basic literacy and numeracy prevalent in some schools today. This does not mean that learning must be dull. Basic number work can be taught just as readily (and much more enjoyably) through games as through pages of "sums". "Scrabble" helps spelling, and nonsense and joke books spur on reluctant readers.

Although some mothers are resident, and often a great help to us, many are only able to visit, and as the afternoon is busier than the morning with visitors our afternoon sessions in school are more relaxed. Art and craft, music and games are enjoyed and parties are held on every possible occasion. Hallowe'en, Christmas dinner, Easter bonnets, a day in France, a trip to Australia, birthdays, landmarks in treatment have all given rise to original parties. These all involve cookery which is a regular event on most wards and from time to time a midday meal is cooked with a group of children. This could be a simple meal like the Italian lunch for a girl from Italy who missed her native pasta, to the Christmas dinner, which is cooked in every available ward oven and assembled at the last moment for a large, festive, hungry gathering.

Outings are a popular and important part of our work. Very quickly the hospital can become a child's whole world, and just as school helps keep him in touch with normality in the strange setting of a hospital so outings help keep him in touch with the "real" world outside the hospital doors and, incidentally, often enable him to learn much more than we can teach him in the classroom. We visit all the local places of interest. H.M.S. Belfast, the Monument and the London Dungeon are very popular. Once a week the I.L.E.A. send a bus for the afternoon which enables us to take the children further afield. There can't be many museums we haven't visited and, in the summer, parks are very popular. Our most ambitious expedition so far has been a day in France enjoyed by three boys from the dialysis unit,



anticipated for weeks and enjoyed in retrospect for many more. On good summer afternoons we try to work out of doors as much as possible and this summer we look forward to using the new children's playground by the Tower. A love of books is something else we try to encourage in the children, so not only do we have a wide variety of textbooks and a lending library but our secretary runs a mobile bookshop which visits the children's wards weekly and where children, parents and staff are welcome to buy.

Coming into hospital can be a disturbing experience for children. In order to help them come to terms with this we have built up a large stock of books about hospitals—both informative and amusing. We have sets of finger puppets of hospital staff, parents and children. We have medical equipment with which the children can play out their experiences and we have a variety of slides, OHP transparencies and photographs—some of these made by the children themselves.

It is obvious that as teachers in hospital our teaching environment is very different from that of any other school. It is maybe not quite so obvious that our role is rather different too. We must be able to make a good relationship at once with the child when he is admitted and with any other members of his family who may be with him. We must then, as we teach him, be constantly aware of his particular needs at that time—his possible apprehension, which may show itself in disturbed behaviour, his discomfort, his unrest when he is not quite sure when he will be going home. We must think of education in a very wide sense and, far from trying to fit the child into any preconceived teaching pattern of our own, be ready with whatever will help him most at that particular time. At Guy's we are fortunate in that the children's school, started so modestly almost 30 years ago, is accepted as an important part of the children's treatment in hospital by the successors of the paediatricians at whose request it began. As the children come back with their parents to out-patient clinics and the success of their medical or surgical treatment is assessed we know that we have done our part well when the families come back to visit us, as often happens, and we recall together some of the good times during the child's hospital stay—success achieved in work, cookery eaten, articles made and still used at home, fun at parties, friendships made. We then know that not only has the child been helped physically at Guy's but that he has been enriched as a person.

Prof.: *Speaks to God / can walk on water / is faster than a speeding bullet.*

There is nothing he doesn't know.

Senior Lecturer: *God speaks to him / can walk on water in an emergency / is faster than an express train.*

Knows everything there is to know about his topic.

Lecturer: *Can talk to the Prof. by appointment / can swim in an emergency / has been known to catch a train.*

Knows what to tell the student.

Student: *Talks to himself / wets himself in an emergency / couldn't catch a cold.*

Doesn't know which building he's in.

DEVELOPMENT OF A MALARIA VACCINE

by Professor S. Cohen, C.B.E., F.R.S.

Malaria remains the most lethal of the human parasitic diseases, widely distributed in tropical areas and having an estimated incidence of 150 million cases per annum. In tropical Africa alone the annual mortality is about one million, mainly among children, and approximately 15% of all clinical illness is attributed to malaria. Eradication measures based upon vector control and prophylactic therapy have proved inadequate in Africa and have produced only transitory benefit in Asia where the current resurgence of malaria is a source of grave alarm. The mortality and morbidity directly attributable to malaria constitute major constraints on economic progress in many tropical and sub-tropical areas of the world. Under these circumstances, the development of alternative methods of control, including vaccination, is of obvious interest and importance.

The chronic course of infection in malaria has often been taken to indicate that development of an effective vaccine was unlikely. However, studies on specific acquired resistance have shown that the immune response is potentially lethal for the malaria parasite and that vaccination may induce greater protective immunity than drug-controlled infections. In addition, the recent achievement of continuous culture of the erythrocytic stage of a human malaria parasite has made feasible the provision of antigen for vaccination. The elaboration of a human malaria vaccine has therefore become a realistic goal.

Malaria infection is initiated through the bite of infected female anopheline mosquitoes which inoculate motile sporozoites into the blood-stream. In mammalian hosts these quickly localise in hepatic parenchymal cells through mechanisms at present unknown. The exoerythrocytic (E.E.) forms become multinucleate and after a variable period (usually about ten days) infected liver cells rupture and each discharges approximately 20,000 E.E. merozoites which attach to specific red cell receptors and invade erythrocytes. The repeated rupture of red cells and reinvasion by erythrocytic merozoites is associated with clinical manifestations of malaria. A proportion of the asexual blood parasites develop into male and female gametocytes which undergo sexual reproduction in the mosquito.

Two extracellular stages of the parasite cycle—namely the sporozoite and the erythrocytic merozoite—are currently the most promising forms for use as vaccines against malaria. The exoerythrocytic and erythrocytic cycles of parasite development in the vertebrate host are known to have distinct antigenic specificities so that these two vaccines act against different stages of the Plasmodium.

Sporozoite vaccination has been developed mainly at the New York University. Inoculation of sporozoites attenuated by irradiation prevents exoerythrocytic development in rodent malarias. Protection lasting about three months is obtained in mice after intravenous administration of sporozoites without the use of adjuvants but such animals are fully susceptible to blood infection. Sporozoite antigens are unstable and readily inactivated by higher levels of irradiation, freezing and thawing, formol treatment or mechanical disruption. Resistance to challenge was observed in a proportion of human subjects repeatedly inoculated through the bite of irradiated mosquitoes with attenuated *P. falciparum* sporozoite. Despite this

demonstration, the practical implementation of human sporozoite vaccination confronts major difficulties. The clinical manifestations of mammalian malaria are associated with the erythrocytic cycle of development. Effective vaccination against exoerythrocytic stages must therefore eliminate all viable tissue parasites since any which mature would induce blood infection in a host fully susceptible to this stage of the parasite. Other constraints in regard to sporozoite vaccination concern the requirement for intravenous inoculation, the present inability to store the vaccine and the problem of producing sporozoites on a scale suitable for mass vaccination. Since neither sporogonic nor exoerythrocytic development is cyclical in human malaria spp., there is at present little prospect for successful serial cultivation of these stages.

Merozoite vaccination has been developed at Guy's in the Department of Chemical Pathology and is based upon isolation of blood stage merozoites by either differential agglutination or selective filtration. In conjunction with Freund's complete adjuvant merozoite vaccines have proved effective against lethal *P. knowlesi* malaria in the rhesus and have protected douroucouli monkeys against *P. falciparum*, the most virulent of the human malarias. The successful, continuous cultivation of erythrocytic forms of *P. falciparum* achieved for the first time last year at the Rockefeller Institute, New York, has provided a potential source of merozoite antigen for mass vaccination. An interesting feature of this vaccine is that it requires no inactivation as merozoites become non-infective for red cells within an hour at room temperature. In addition, the vaccine can be stored after freeze-drying and immunity is directed against the stage of the parasite causing clinical illness.

Several problems remain in regard to the development of a blood-stage malaria vaccine suitable for human use. Apart from excluding pathogens there will be a particular problem of contamination with blood group substance if the present techniques are used for cultivation of malaria parasites. A further problem concerns the requirement for the clinically unacceptable Freund's complete adjuvant in vaccines such as those which have proved effective against simian malaria. The relevance of such experimental models to human populations is difficult to assess. Susceptibility to malaria is influenced by many factors including blood group specificity, haemoglobin constitution and genetically determined differences in patterns of immune responsiveness. There is evidence in human populations that malaria selects for genes controlling not only haemoglobin synthesis and blood-group specificity, but also HLA specificity. The immune response of a given population to malaria vaccination is likely to be strongly influenced by such antecedent selection. The adjuvant requirements in exposed subjects may, therefore, be less stringent than in experimental malaria which relates almost exclusively to infections in unnatural hosts. The present stage of development of this work suggests that controlled field trials of a vaccine directed against the erythrocytic stage of malaria may be undertaken within the next three to five years.

THE HOSPITAL CHAPEL, *continued from page 145.*

of Mrs. Grace Wells. Since that date some girders have been put under the ceiling to strengthen the floor above, and these will have to remain until this West Wing is rebuilt.

The prevailing colour of the present decoration is off-white, Wedgwood blue, and silver. The blue of the six mosaics is "taken up" in the ceilings above the side aisles, and the central moulding of the main ceiling is picked out in blue. The nine-branch chandelier has been silver-plated. The arms over the Guy Memorial have been emblazoned to their proper colours, and the inscription has been carefully picked out in black. Over a year ago the silver crucifix and candlesticks were stolen from the altar, and these have now been replaced by some simple candlesticks, and a lovely silver-coloured figure of the Risen Lord moulded in fibreglass. The hands bearing the marks of the nails are stretched out in welcome, while the figure of the Risen Lord may serve as a reminder that suffering and death do not have the last word, and that through His power both can be transformed into something new and lovely. Perhaps there could be no more appropriate message for the chapel of a great hospital.

The present redecoration has been made possible with money allocated by the Health Service through the District Management team. It is good to know that such a priceless heritage is still being cared for, and speaking of the things of God to all who enter.

The Reverend Robert Kempster,
The Chaplain.

PLEASURE AND PREVENTION
EFFECTIVE PREVENTION WITHOUT BEING A KILL-JOY

By Jennie Popay and Peter Draper
Unit for the Study of Health Policy

Bristol, 16 March 1984.

"Will S. Player, the brilliant young research scientist who synthesised the active constituents of the forbidden weed tobacco from Welsh bog Myrtle, was gaoled for 21 years here to-day by Mr. Justice Parkson for 'misguided loyalty to a family business which had brought misery to millions'." (New Society, March 1984.)*

Parliament, April 1984.

"The speed limit on all roads except motorways will be set at 20 m.p.h. (25 m.p.h. on motorways) and the rush hour restriction on the use of private vehicles in built-up areas will be extended to all daylight hours." (Minister for Secure Societal Health.)

The Big Brother images of restricted freedom illustrated above are associated by many people with any wide-scale acceptance of preventive medicine. A wide range of opinions exists with regard to prevention from those who hold it to be totally ineffective to those who see it as the cure for every conceivable health problem. Furthermore, something of a "Prevention Bandwagon" has followed the questioning in many countries of the basic rationale of high-technology medicine and the growing realisation within even the richest countries that the resource trends of modern scientific medicine cannot be sustained. However, prevention has not yet been treated to an informed and thoughtful public or professional discussion. Furthermore, the political feebleness—or worse, the cynicism—of praising prevention yet giving it a tiny proportion of the N.H.S. budget is self-evident and fosters a very limited view of the potential contribution of preventive measures.

* Based on a comment in *New Society* 16th March 1978.

The major thrust of this paper is an attempt to show that taking prevention more seriously should lead neither to the restriction of individual freedom nor to the "eradication of pleasure". Perhaps it is relevant first to note some of the other arguments against prevention. One of the most pervasive criticisms is that levelled at the empirical basis for certain preventive measures. Certainly there is imperfect knowledge of many of the causal links between environment and lifestyle on the one hand and sickness and death on the other. But some factors are more clearly linked than others—who could honestly question the positive impact of providing safe skateboard centres or reducing drunken driving? With other factors, the links, though weaker, are strong enough at least to suggest "prudent courses of action" whilst better knowledge is obtained. For most people, reducing their intake of animal fats might be an example of a prudent policy.

It has been argued that preventive medicine can foster a belief in "conquering disease", indeed, in a phantasy of immortality. This criticism has of course also been levelled at other branches of medicine. It is perhaps sufficient to maintain that the promotion of health—of thriving, the avoidance and reduction of suffering and the avoidance of unnecessary and premature death, seem to be the proper concerns of *all* branches and activities of the health field—whether preventive, curing or simply caring.

Despite the current interest in prevention, there would appear to be no general understanding of what it could entail nor what the most effective means for its delivery might be. At the risk of over-simplification one can distinguish two contrasting approaches to prevention—the individualistic, "be good" approach and the more broadly-based attempt to tackle the underlying causes and shaping forces of contemporary trauma and illness. In a working document published in 1974, Marc Lalonde, the then Canadian Minister of National Health and Welfare, clearly elaborated the policy implications of the second approach. *A new perspective on the health of Canadians* argued that the answers to health problems must be sought in *four* areas, in the organisation and provision of health care and curative services, in human biology, in the environment, and in lifestyles. From this perspective, the "self-imposed" risks related to problems such as obesity, cigarette smoking and the abuse of alcohol and drugs, cannot be viewed as the result of purely *private* choices. Such choices are clearly subject to a variety of influences over which different individuals have varying degrees of control. The social and economic pressures must be the focus of attention. These range from certain kinds of advertising to damaging stresses which promote the consumption of tranquillisers of all kinds, from cigarettes and alcohol to pills and potions. The basic premise is that the "whole" environment within which health-related choices are made needs to be considered, and where there is general agreement that this is desirable, changed. Change of this magnitude requires far more than a "do it yourself" approach. The approach we favour can be regarded as "holistic" prevention.

As happened with the ideals of the welfare state—the (admittedly rare) "dream" of a health-promoting environment has been eroded to a "much less glorious reality". For instance, in our own Government's document *Prevention and Health: everybody's business,* social and economic pressures are largely ignored or discounted and the key to prevention and healthy living is seen to lie mainly in the area of individual will-power and self-motivation: "Be good and pull yourselves together—don't smoke, don't

drink, don't eat too much and so on." The role of Government is mainly restricted to a little money for exhortation and preaching—"educational campaigns"—and more recently to limited monetary incentives and disincentives (such as a health tax of 7p a packet for 15% of the cigarette market).

It is perhaps because of this confused and superficial approach that prevention has come to be seen as "kill joy". Such views are based on the mistaken premise that the basic approach of prevention should be to tackle individuals and individuals alone!

"Holistic prevention" does not imply that individuals should "stop enjoying themselves", rather it means that decisions in terms of lifestyle and environmental quality, for example, can be taken within a broader and more realistic framework. It is not a question of *restricting* freedom or *forcing* choices, rather it is the development of an environment within which people can exercise *greater* choice and within which the *healthier choices* can become the *easier choices*. At the very least, choices which affect health should surely be put on a level footing with other options.

This is not the place to do more than raise the question of whether Western societies are currently tending to teach a conception of pleasure that is dependent on the existence of external stimuli. It is arguable however that we are failing to teach the ability to fulfil ourselves from within, to value relationships with others and, by forgetting something of a Franciscan spirit, failing to teach the joys of the simple life. A book like Patrick Rivers' *Living Better on Less* is a striking exception and stands in stark contrast to the glossy magazines and colour supplements. Such questions are central to the idea that encouraging and actively promoting prevention necessarily means restricting "pleasure". Who can honestly claim that they *enjoy* the aftermath of a heavy drinking session or the breathlessness and other discomfort which accompany exertion when one is unfit? Rather, we need to remind people that to be physically fit is *pleasurable*. To characterise vigorous exercise as intrinsically painful, healthy food as uninteresting or "cranky", cycling as boring and so on, is to *restrict* people's experiences.

An imaginative and energetic approach to holistic prevention would affect many policy areas. The breadth of this is amusingly illustrated in an article by Lipton* in which he imagines the existence of a "Special Cabinet Committee on Positive Preventive Health". Chaired by the Prime Minister, it includes the Ministers of Agriculture, Education, Finance and Planning, Industry, Overseas Development, Sport, Trade and Transport. As he notes:

> "When one defines a problem such as that of positive preventive health instead of operating conventionally, the boundaries of demarcation between conventional ministries become irrelevant and the same applies to the boundaries between conventional disciplines."

Space will not allow detailed discussion of the specific measures that follow a broader perspective but a few *working* examples will illustrate how the healthier choices can be made easier without resulting in less pleasurable or restricted lifestyles.

In 1974, the Norwegian Government introduced a comprehensive programme to encourage a healthier pattern of food consumption and to make Norway more responsible internationally by making it more self-sufficient in

*Institute of Development Studies Bulletin, Vol. 9, No. 2, December 1977.

food production. It is attempting to achieve change through a combination of pricing subsidy, production and educational policies to help people to change their dietary habits in healthier directions. Education will provide a basis for people to acquire the needed skills and knowledge to become more self-sufficient through a better understanding of nutrition, but other measures will affect the available information and the supply of food and drinks, thereby improving the "environment" within which the skills and knowledge will be used.

There is clear recognition in the Norwegian Government statements that what is in fact "healthier" is always open to new knowledge but they maintain that *sufficient* knowledge is available to recommend alterations in the diet which are desirable or prudent from the point of view of preventing disease. Obviously such policies will have far-reaching ramifications, but providing complementary policies are implemented to address any resultant problems (such as employment changes) and provided that change is implemented carefully, there is no reason why in principle such health-promoting policies cannot be put into practice more widely.

Such policy initiatives are a far cry from the "kill-joy-doom-scenario". There is no luxury level of VAT on sweets, no prohibition of alcohol or cigarettes, no rationing of "harmful" products—rather, it is a careful programme of *encouraging and enabling healthier choices*. Critics of government interference should perhaps not lose sight of the adage that inaction affects decisions as much as action—the individual's right to choose is not and never has been "uncontaminated" or "unfettered", free from social and economic pressures.

Close to home and perhaps on a less ambitious but no less important scale, passing mention could be made of the creation of cycleways in Hyde Park providing a pleasant and *safe* means of exercise and travelling. How many other cycleways could be designated or constructed in Central London with minimal effort and cost?

It should be apparent then, that a holistic approach to prevention involves the provision and increased practicality of alternative joys and pleasures rather than the prohibition of, or weaning from, existing gratifications. The central premise is not exhortation but the implementation of policies which make it *easier* and *pleasurable* to change lifestyles. All of this is not to suggest that we should neglect the *curative* and *caring* services. As the Unit suggested in an earlier paper,* the debate about the appropriate role of modern medicine is not a debate about choosing prevention or cure (as the Greeks would have put it, choosing Hygieia or Asclepius), rather, it is a debate about whether advanced industrialised societies can strike an appropriate balance between the two.

The role of true prevention is well summarised by Lipton at the end of his futuristic paper:

> "The well-being of a nation depends on three things . . . the output of goods and services, their distribution . . . and the volume and distribution of people's capacity to enjoy what they get . . . to asborb goods and services and to transform them into physical and spiritual welfare."

What kinds of things does this imply? We think it means that we need to question the kind of economic "growth" that we pursue so fervently (even

*Royal Society of Health Journal, June 1977.

if we don't achieve growth); that we need to question the distribution of massive production and the neglect of government's "general responsibility to improve the capacity of the governed for the absorption of welfare" (Lipton).

Such questioning may lead to the realisation of the vision of a *healthier* nation with enhanced and perhaps saner concepts of pleasure and enjoyment rather than a nation subject to restricted freedom and "*no joy*". You have to be pretty sick to view such things as the tobacco diseases, traffic slaughter and cirrhosis as essential or inevitable components of a lively and creative society. "Health professionals" surely have some contributions to make to a healthier, a saner society. "Without vision, the people perish" (Proverbs xxix, 18).

TREATMENT CONTRACTS AT THE YORK CLINIC

by Dr. Bernie Rosen

Hospital admission can be a confusing business and never more so than for the psychiatric patient. Apart from any direct effects of his disturbance, our patient is likely to suffer from more than the usual problems of understanding the mostly unspoken rules of parenthood. Unlike someone admitted to an acute medical or surgical bed, our patient will experience greater difficulties in identifying the source of his distress. He may (often) blame himself or regard himself as a failure, hospital may be viewed as a punishment but sometimes it becomes a refuge to which patients cling with desperation.

Evidently, the patient's view of his experience can be at considerable odds with the intentions of his therapists.

The in-patient contract developed as a response to these special problems of admission but it has become obvious that contracting a patient to treatment has other significant advantages which I will discuss later.

When patients are admitted to my unit in the York Clinic, they are invited to take part in a kind of negotiation and are told at the outset to think about and try to set out some of the problems for which they are seeking help. This in itself is a novel idea for the patient who may be expecting to be told what his problems are. Devising problems is clearly not always an easy task for the patient, and he is aided by a number of discussions with staff members, and other patients. By the end of a few days' assessment the patient and staff arrive at a list of problems and then a contract meeting between patient and staff is held. A formal document, the treatment contract, is drawn up in four parts and deliberately framed in a legalistic manner.

The first, the introduction, explains the purpose of the contract and emphasises the need for the patient to co-operate. Next is a joint statement by patient and staff about the agreed aims of treatment and the intended period for their completion. The third section is an undertaking by the staff about how *they* will go about treating the patient, and the expected benefits and possible side effects are also stated in this section. In the last section, the patient undertakes to play his part in treatment as described for each treatment goal. Additional undertakings and agreements may be made; for example, special privileges or undertakings to avoid certain kinds of self-destructive behaviour.

The document is drawn up section by section and the patient is encouraged to state his opinions as openly and frequently as he likes and to negotiate and then sign. On completion, a copy is given to him. The staff also sign their copy of the contract.

Treatment contracts are, of course, an already established part of hospital practice, for example, with patients receiving a general anaesthetic but the procedure described here however, is a far more extensive undertaking.

The most obvious effect of contracts is to give the patient a clear understanding of what treatment is about which is important in any branch of medicine, but particularly so in psychiatry. Equally the opportunity is provided for a problem oriented approach to treatment and while this is accepted practice at Guy's it presents special problems for psychiatry because psychiatry tends to get rather fuzzy at the edges since the psychiatric patient is likely to present with intercalated multiple pathology.

The problem oriented approach has a very significant implication in that it is drawn up in terms of problems rather than in terms of illness or diagnosis. This automatically alters the role of the patient from a passive consumer of health care to a problem solver. I think that encouraging this activity is in itself a valuable "treatment" because a major determinant of patienthood in psychiatry can be seen as a reduction or insufficiency of problem solving skills.

The next important aspect of the contract is that it is negotiated. This suggests that the patient has something to say which the staff agree to take seriously (not always standard practice in medicine!). In itself, this may contribute to a raised sense of self-esteem, the lack of which is a frequent finding in psychiatric patients. Secondly, the patient is forced to realise that he too has responsibilities which are written into the contract. Hopefully this aids in preventing the formation of maladaptive long-term passive, dependant relationship with staff.

Most importantly, negotiating a contract also approximates to real life situations where we spend much of our time "negotiating" our various needs and relationships. The process of making a treatment contract is treatment in itself.

SALMONELLOSIS

by Dr. Denis McCance

Food poisoning is increasing due mainly to changing eating habits and the intensified production of food. Added to the traditional bacterial agents, viruses (most as yet unclassified) are also involved. The most common aetiological agent is the Salmonella group of bacteria and the incidence of food poisoning caused by these organisms has been steadily increasing from 6,000 cases in 1969 to 9,000 in 1975 but a drop to 7,500 in 1976. These are only the cases reported to the Public Health Laboratory Service and are probably a gross underestimation. The Americans estimate that only 1% of cases are reported to their public health services.

Human infections with salmonellae have to be divided into three groups: those bacteria which colonise and infect man only, *Salmonella typhi* and *S. paratyphi* A and B, causing enteric fever, those which specifically

infect animals (*S. pullorum* in poultry) and the large unadapted group which colonise and infect animals and are passed to humans by consumption of contaminated carcases. In most western countries disease caused by the former group of organisms has been virtually eradicated due to public health measures and most cases in Britain are imported by people travelling or living abroad resulting in family outbreaks, or from contaminated foods which lead to larger outbreaks. The latter group of salmonellae organisms contain a large number of different serotypes which are ubiquitous and colonise many animals. Although the disease produced by these animal serotypes is milder and non-invasive, with acute gastroenteritis as the most common symptom, death can occur in susceptible groups such as the very young, or old. The most prevalent serotype found in human infections is the organism *S. typhimurium*, but while this has remained fairly static over the years other serotypes such as *S. agona* and *S. virchow* infecting poultry and pigs have increased. These organisms were introduced into animals by animal feeds imported from South America.

In the light of the increases and changing patterns of salmonella infections, the British Association for the Advancement of Science (BAAS) have produced a booklet called "Salmonella—The Food Poisoner", with the aid of farmers, veterinarians, meat inspectors and members of the medical profession. The booklet sets out in relatively elementary form the infections in man and animals and the routes by which these groups become infected. It discusses the effects some of these organisms such as *S. typhimurium* have on the pocket of the farmer, as this organism can decrease milk production, cause abortion and death in young calves—effects that make the farmer try to eradicate the organism from his herds. Unfortunately the salmonellae infecting birds cause little or no clinical disease in these hosts and so the inertia this instills makes the poultry industry one of the major distributors of salmonella among the human population. Various surveys at packing stations show that 3% to 60% of birds carry salmonella organisms, but the booklet does show that food handled properly by the consumer will minimise any chance of infection even from these contaminated carcases.

The BAAS is concerned with the changing pattern of infection in animals introduced by imported animal feed and transmitted within herds by the intensive farming that is needed to supply the quantity of food we all demand. Some of the practices used in this type of farming such as antibiotic additives in food to accelerate weight gain have been legislated against at least as far as medically important antibiotics are concerned. There was and still is the real fear of spreading antibiotic resistance among important pathogenic organisms. One area where legislation has been slow to introduce control is in the killing of animals at the abattoir. Dual standards are employed depending on whether the meat is for export where, under EEC regulations, veterinarians are required to supervise the process while for the home market this is not necessary. Veterinarians argue that their presence would mean any cases of Salmonella contaminating meat could be traced back to source more easily by their diagnostic back up, while meat inspectors feel the present situation is satisfactory. While this disagreement goes on, infected animals are entering the market.

The booklet should be read by all those in various branches of food production and preparation from the farmer to the chef and medical and nursing personnel since according to the PHLS 38% of general outbreaks occur in hospitals. The booklet is short and readable and lays down the areas

where a start can be made in reducing the instances of Salmonella poisoning. Personal hygiene is important as an infected person may carry and excrete the organism for up to eight weeks after clinical symptoms have disappeared. They quote the case of bovine tuberculosis which has been eradicated from herds in many parts of the world with the result that this bacillus is rarely seen as a cause of TB. Perhaps salmonella will be a tougher nut to crack but a booklet such as the one produced by the BAAS highlights the problem and hopefully helps us see where we can contribute to its elimination.

NURSING

Morale in the National Health Service

During recent months, much space has been devoted in the press to commenting upon the low morale which at present exists amongst workers in the Health Service. Nurses, it seems, are despondent about the constraints put upon them which prevent the maintenance of acceptable standards of care, whilst doctors are either queuing to work abroad, or hiring public halls in order to tell potential patients the reasons for their interminable waiting periods before admission to hospital. One of the latest developments has been a letter to the Department of Health, from the General Secretary of the Royal College of Nursing telling him of the grave situation.

Those nurses who are employed in the hospital service have, of late, been put under pressure, which at times has proved to be intolerable. The low staffing levels have necessitated the closure of fourteen casualty departments in the London area alone, a number which represents twenty-five per cent of the total.

The root cause of the problem, is shortage of money with which to finance the employment of nursing staff. All hospitals have experienced severe difficulties, but in London, not only was there a general reduction of money due to the economic situation in the country, but the Government in its short sighted wisdom also saw fit to divert finance from the Metropolis to other areas, despite the fact that the London hospitals carry a heavy responsibility for both research and the provision of a referral service for the rest of Britain and countries overseas.

The result of this is hospitals which are critically understaffed, and five thousand unemployed nurses, which appears to be a somewhat paradoxical state of affairs. Over and above all this, there are long lists of patients awaiting admission to hospital and who are receiving a service which is even less efficient than usual.

The governments of this country never have held the provision of health care high on their list of priorities, and always allocate too few funds for the running costs. The members of the Government may not feel they require such facilities, since they themselves can seek private treatment despite their public antipathy towards it. They seem to forget that much valuable revenue comes into the country from overseas patients, as do donations for the provision of expensive specialised units.

It seems that unless a large amount of money is directed towards health care in the fairly near future, morale will have reached such a low ebb, that recruitment of staff will become impossible, and the suffering of the patients increased to an even greater degree.

Pam Jefferies.

PHYSIOTHERAPY

The number of young women wishing to enter physiotherapy training has increased to the point where, over the country as a whole, only one in every four will be successful. In the more popular schools the odds against being accepted are even greater and selectors are faced with the knowledge that candidates who do well but not quite as well as their competitors are very unlikely to get a place anywhere else. This is despite the clearing house system which allows one to list eight schools in order of preference, and is explained by the fact that even those less popular schools now have the ability to complete their intake with their own first choice candidates. Unlike students using the U.C.C.A. system, physiotherapy applicants are dealt with by only one school at a time and the probability is that by the time the first school has considered, interviewed, meditated, rejected and notified, the second and subsequent schools have already decided which sow's ears they will try to transform into silk purses.

Why physiotherapy should have become relatively so popular is explained by a number of circumstances. There is a larger number of post "A" level school-leavers, teacher-training colleges have drastically cut their intakes, university graduates are widely believed to have difficulty in finding employment, and knowledge of what physiotherapy can offer both to its recipients and its practitioners continues to grow. It is striking how many graduates and undergraduates are writing to enquire about their prospects of being accepted for our vocational training, at the end of which, of course, employment prospects are excellent.

We could get carried away with a fulsome sensation of popularity, and raise the academic threshold still higher—even press for an all-graduate profession—and there are good arguments to support such developments. We would be well advised, though, to keep an eye on population projections into the 1980's, because we could in seven or eight years' time, find that we are having to compete with other "further educators" on less favourable terms and be forced to the embarrassing lengths of having to lower any inflated pre-entry requirements.

In any case, academic abilities are only one aspect of the past attainment and future potential that the health-care professions should be seeking to find in their applicants. How can we make an objective assessment of warmth of personality, humane attitudes, encouraging and stimulating "vibrations", to use a time-expired phrase? Yet these are as important in a physiotherapist as an ability to pick up two or three good "A" Levels.

Much criticism has been made of selection by interview and, it is frequently difficult satisfactorily to account for the choice of one and the rejection of another in response to a head-teacher's or a parent's request for an explanation of unexpected results. But this sort of "feeling" for a good candidate is bound to operate in a situation where on paper, all the geese are swans and there are many, too many of them anyway.

Ronald Cooper.

BOOK REVIEWS

"Relationships Between Doctors and Patients", edited by Alan Davis. Pp. 158. Price £7.50. Published by Saxon House, Farnborough.

I think this book has the wrong title. There is nothing much here about how doctors and patients understand, care for, establish rapport with, respect, trust, have problems with each other—to mention some of the things conjured up for me at least by the term "relationships". This is not immediately about clinical practice except in a subversive way—"the picture that emerges shows the worrying extent to which relations between doctor and patient tend to be rule-governed and routinised".

This book is about some sociological approaches to some medical matters, and, as such, is most interesting. It comprises an introductory statement followed by sociological essays concerning a dressing clinic, ENT outpatients, antenatal practice, and the management of cancer patients. We read about the agenda, negotiation and power battles occurring in doctor-patient meetings and of the varieties of social model implied by medical activity; and we learn of problems which supposedly arise from trying to treat pregnancy as if it were an illness.

The problem I have with all this is not that I think sociological concepts are invalid or obfuscating—I find some of them (inasmuch as I understand them) clarify and extend my views of psychiatric and medical work most helpfully. My problem is with what I might call the sociologists impotence. Strictly he is only an observer and analyser, and has no grounds as a sociologist on which he can base judgements about what ought to happen. Sociologists actually do keep making statements about what ought to happen, but this is naughty, because they step outside their field of competence without saying so.

This is a singularly clear bit of medical sociology and well worth reading.

J. P. WATSON.

"Doctor and Patient in the Teaching Hospital", by Cecilia M. Roberts. Pp. 140. Price £9.40. Published by Lexington Books, 1978.

There are basically three ways of researching the doctor-patient relationship. The first is the "survey" technique in which selected samples of doctors and patients are given questionnaires or interviews and the results tabulated and analysed.

The second approach is to examine the doctor-patient relationship from the point of view of the belief systems of the two participants. In this area there have been valuable studies—particularly by Ackernecht and Foucault—on the emergence of the particular way of defining health problems that characterises Western medicine.

The final approach is the ethnographic which has been popularised by anthropologists. Here the investigator observes—with various degrees of participation—the behaviour of the subjects. Fascinating descriptions of tribal practices which have served as useful data bases for later research and analysis have emerged from many of these studies.

In this book Dr. Roberts ignores the first and second approaches. She acknowledges her sample is not "scientifically selected", she offers neither questions nor interviews to her subjects and she makes no mention of the historical/belief system approach. Instead she concentrates on an ethnography of teaching hospital life. In this she is far from successful.

The reason for her failure is partly the difference between a primitive tribe and a modern hospital. While the study of the Azande offered new material for anthropological analysis the happenings in a teaching hospital, which Dr. Roberts draws upon, are the well-known bread-and-butter of the supposed medical readership of this book. The book offers nothing new to those working in teaching hospitals who keep their eyes and ears open. Even those who walk about in a daze would not find the conclusion, that the doctor-patient relationship can be improved by mutual awareness and mutual education, particularly earth-shattering.

The main regret I have about this book is that it tends to reaffirm the frequent charge that behavioural science is concerned with the study of the obvious. The only thing obvious to my mind is that this book is truly awful.

DAVID ARMSTRONG.

"The New Sex Therapy: Active Treatment of Sexual Dysfunctions", by Helen Singer Kaplan. Pp. 589. Price £3.95. Published by Penguin, 1978.

Sex is one of those emotive subjects like politics and sport, the discussion of which drives most people to extremes of opinion. Those whose sex lives are satisfactory find it difficult to appreciate those cases who are experiencing difficulties. After all, what goes on behind bed-

room (and other) doors is essentially a private matter which until relatively recently was not open to objective enquiry, so that attitudes to sex and sexual knowledge were largely determined by subjective considerations.

However, Alfred Kinsey, William Masters and Virginia Johnson (Mrs. Masters), Michael Schofield in this country and a handful of others have changed all that and many studies of a sociological, psychological and physiological nature have been reported over the past few years.

This volume brings together the many diverse threads relating to human sexuality with relevance to sexual problems and their treatment. The author, Dr. Kaplan, a very well-qualified American psychiatrist, runs a New York hospital.

This paperback edition makes its appearance four years after the first handbook version appeared in the United States. It is a long book (over 500 pages) sprinkled with nearly 40 case studies, over 20 illustrations and several tables and so one is thankful that she writes well. Dr. Kaplan describes the biology of sex and the biological and psychological causes of sexual dysfunction—and the dysfunctions themselves before going on to explain the principles and practice of the various methods of treatment. These include both psychotherapy and behaviour therapy and mixtures of both. The final chapter, written by Dr. Clifford Sager, discusses the role of sexual dysfunction marriage.

Dr. Kaplan avoids use of the negative labels "impotence" and "rigidity" and chooses to classify the six major sexual dysfunctions descriptively as: in men, erectile dysfunction, premature ejaculation and retarded ejaculation; and in women, general dysfunction, orgastic dysfunction and vaginismus (contraction of the vaginal muscles which prevents penetration).

The results she reports are significantly better than those obtained using the more traditional psychotherapies and relate to those patients "who suffered from a specific sexual dysfunction, but were basically healthy otherwise and had essentially good marriages". Those who were suffering from a more general psychological problem and who were involved in destructive marriages are less easily cured (with the exception of premature ejaculation and vaginismus where the outcome of treatment seems to be relatively independent of any other psychological disturbance). However, it is rather difficult to evaluate from the author's presentation the active ingredients of treatment, since these are not controlled systematically. Dr. Kaplan admits that some dysfunctional patients "fail to respond to sex therapy for reasons which we do not understand". One thing is certain though: a good outcome depends on having a good sex partner co-operating during treatment.

One of the great advantages of Dr. Kaplan's eclectic approach, combining psychotherapy and behaviour therapy on an out-patient basis, where patients practice sexual tasks at home, is that treatment is usually complete within 10 to 15 sessions.

There are many fascinating facts to be found in Dr. Kaplan's book. One point to note however, is that the concept of love does not make its appearance until page 523, the penultimate page.

Her book is well worth reading and is a must for those with a professional interest in the subject. It complements well her later offering, the large-format **Illustrated Manual of Sex Therapy** (published in the U.K. in 1976), which, no doubt, will find its way between soft cover before too long.

MAURICE YAFFE.

"Everywoman—A Gynaecological Guide for Life" Second Edition, by Derek Llewellyn-Jones. Pp. 382. Price £1.10. Published by Faber & Faber, 1978.

Here is the second edition of a book by a Sydney gynaecologist, designed to capture the interest of the liberated lay woman. Although obviously well attuned to the virago press and the feminist movement, Mr. Llewellyn-Jones avoids the stridency of his compatriot Germaine Greer, although occasionally flopping into a "so long as you are enjoying yourself it's all right dear".

The book is in three parts; the first quarter devoted to a sociological view of feminity, with a list of coital positions including the notorious soisante-neuf; the middle half covers childbirth in some detail with good illustrations and advice on breast care and post-natal exercise; and finally the small last section covers some common gynaecological problems. I will take no great notice of the childbirth portion, for I believe this area is better covered by other books on the market such as Lennart Nilsson's "A Child is Born" and Sheila Kitzinger's "The experience of Childbirth". The opening section on femininity and its general problems is interesting, although it appears to fall over itself to please the

modern liberated woman and consequently lacks bite. Statement such as "women have no less enthusiasm for sex, no less enjoyment of sex and no less sexual drive than men" are made authoritatively without any scientific backup and only with the Hite Report, and Masters and Johnson included in the bibliography. However, Mr. Llewellyn-Jones' views are generous and he is obviously better read than the short bibiliography suggests.

The gynaecological section is short and well presented, covering pre-menstrual tension, period disturbances, obesity, hormone replacement therapy and the menopause, breast lumps, chronic urinary infections and sexuality after the menopause.

Looking through the available paperbacks for the lay reader in our local book shop, I found no other books that covered these topics and for this reason the first edition has sold well in Tunbridge Wells and Mr. Goulden (our bookseller) has expectantly ordered the second edition.

Some of the writing is turgidly textbook in manner—"the uterus is a hollow muscular organ, etc." and some is luridly romantic—"the menopause is but a milestone along the road, etc.", but mostly it is well written and in a field dominated by sociological writers, it is good to have a gynaecologist's balanced view. The illustrations are good and some, such as that on the chromosome contribution to the child from each parent, illuminating.

I will certainly add this book to my patients' library and I agree with my wife, who said it should be compulsory reading for all husbands.

TONY MEMBREY.

"Accidents and Emergencies: A practical handbook for personal use" 2nd edition, by R. H. Hardy. Pp. 108. Price £2.50. Published by Oxford University Press, 1978.

This is the second edition of a handbook written to assist staff coming to Casualty for the first time. It consists of items arranged alphabetically on the left hand page with the right hand side blank for the reader to write his own notes.

A weakness of the alphabetical approach is that it causes unnatural separation, e.g. hand injuries are separated by other subjects from tendon repairs—hand, and dislocations from fractures.

Detection and diagnosis are of prime importance in the Casualty Department but some sections of this book lay insufficient stress on these aspects, e.g. fracture of the neck of the femur is covered by two lines on first aid, and dislocation of the lunate is described in two lines on treatment and one on avascular necrosis.

The Casualty Officer, when he takes up his new appointment, finds a changed emphasis is necessary in his approach. His previous training has often given little attention to the care of the problems of patients in Casualty. A well educated doctor adjusts quickly to the change but needs a guide during his early weeks if he is to work effectively and maintain his standards. Every effort to provide such a guide is to be welcomed and there are some good sections in this book. It will be bought by many Casualty Officers and they will obtain some assistance from it.

Major-General N. C. RODGERS.

"Gastrointestinal Angiography" by S. R. Reuter and H. C. Redman. Pp. 390. Price £20.00. Published by W. B. Saunders, 1977.

This is the second edition of a monograph first published five years ago. Much has happened during these five years to define the place of gastrointestinal angiography, with the wide availability of newer forms of medical imaging, and these changes are reflected in this book. It reviews the equipment and techniques used, and includes a section on superselective catheterisation. The vascular anatomy of the gut is described in detail, and the full scope of angiography discussed, with particular stress on its role in gastrointestinal bleeding. There is a brief chapter on pharmacoradiology. The book is profusely and clearly illustrated, and comprehensive references are provided.

The book reflects the obvious enthusiasm of its authors, and at times perhaps is given to overstatement. It is however an excellent account of the state of the art, and will be a most useful reference book for radiologists. It will provide interested physicians and surgeons with a detailed statement of the scope of this branch of radiology.

At £20.00 this is an expensive book, but it can be recommended in spite of this.

MAX RENDALL.

"Pharmacognosy" 11th edition, by G. E. Trease and W. C. Evans. Pp. 784. Price £12.50. Published by Baillière Tindall, London, 1978.

Pharmacognosy is that branch of pharmacology concerned with the biological sources and biochemistry of natural drugs and their constituents. A hundred years ago this would have been a major part of the course in pharmacology for medical students and many physicians of that time were expert botanists. Pharmacognosy has remained in the syllabus for schools of Pharmacy and the present volume is the 11th edition of the standard British text on the subject. The first third of the book deals with the botany of plants containing drug substances. The next third with methods of extraction and preparation of drugs from plants and animal sources. The final third is concerned with identification of drugs from natural sources. For the non-expert, such as myself, it is interesting to see pictures of the plants which are usually given only cursory mention in pharmacology textbooks as being sources of drugs such as digitalis, atropine and jalap. The phytochemistry is complex and I'm glad I didn't have to learn it as a student. Fortunately none of our students will have to know anything about pharmacognosy and so apart from general interest reading, and you would have to be very interested to read a whole text book, I would not recommend this book for the medical or dental courses at Guy's.

HOWARD ROGERS.

CORRESPONDENCE

Biochemistry and Medicine

Dear Sir,

I have read with interest the letter from your correspondent W. Scott-Smith in the February issue of the Gazette concerning my comments to Mr. Razzell on the Basic Medical Sciences Biochemistry Course. I made it quite clear in my interview that I disapproved strongly of the "new brush sweeps clean" approach because my considerable experience, stretching over 10 years of development of modern BMS courses, has taught me that courses must evolve rather than be the subject of radical, drastic upheaval; clearly this is experience that your correspondent lacks. It is a pity that he is unwilling to await the testing of the flavour of the pudding that will be evolved but instead is allowing his prejudice to prejudge the issue by his sarcastic comment that "what is *said* is not necessarily *done*", an attitude that is scarcely helpful.

The relevance of biochemistry to medicine is a matter about which I hold strong views. However, I cannot accept the implication in your correspondent's letter about irrelevance of metabolic pathways; intermediary metabolism is the very stuff of biochemistry and it is in an understanding of the overall, integrated picture that the key lies to the application of biochemistry in the treatment of disease. It is sad indeed that Mr. Scott-Smith has failed to realise this fundamental truth.

I am grateful to your correspondent for his views on the practical course and will endeavour to avoid the "grave error" about which he issues his caveat. I can assure him that the practical course is being subjected to scrutiny and that I shall, in the fullness of time, introduce such changes as I see to be fitting and necessary.

In the two short months that I have been at Guy's major proposals for changes in the BMS Biochemistry Course have been made and are currently under discussion both by the staff and by the students. I have been greatly helped in my task by discussions with groups of students, as well as by the constructive criticism that I have had from members of SMEC, and I welcome discussion and criticism of my efforts. It is only in this manner, by experimenting and learning by the inevitable mistakes that may be made, that the excellence that Guy's deserves can be continued in the light of the demand upon Basic Medical Sciences by developments in Clinical Science.

Yours faithfully,

ANTHONY DIPLOCK.

Biochemistry and Chemistry Department,
Guy's Hospital Medical School,
London, SE1 9RT.

P.J.R. is innocent, OK

Dear Sir,

Having completed my review of "Ruddigore", as performed by the Guy's G. & S. Society. I felt that, having performed in several of the Hospital's musical activities in the past, and still being on speaking terms with one or two of the cast, that a pseudonym would be appropriate, in order to remain on speaking terms with those members of the cast who might take exception to what I had said! Judge, then, of my surprise, when, opening my Gazette of the 18th of March, I found my review graced by the hardly very Anglo Saxon name of Alcibiades Skinner. Either by an oversight, not entirely excusable in the circumstances, or by the mischievous

sense of humour of the tallest member of the Gazette Committee (you know, the one with the moustache and glasses, who keeps cats in his flat in Sydenham), my identity has been revealed.

Having got that off my chest, along with the other ailments that have affected me all winter, I should like to add a personal note to my review.

Sean Tighe, in his excellent performances, gave no hint that he had had barely a fortnight before the production (after returning from his elective) to prepare his part. As he takes finals this year, his departure will leave a very great hole which will be hard to fill, and surely the thanks of both the G. & S. Society and the Music Club are due, for the delight and entertainment he has given to so many people.

I should also like to say that the G. & S. Society is, again, the poorer for losing Ian Page, as he also finishes this year. His unfailing work rate behind the scenes, his production of "Pirates", his organisation behind the scenes in "Ruddigore", and above all, his facility for doing all the little (but essential) jobs which would otherwise be forgotten in the pre production madness, have all too often gone unnoticed, and he, also, deserves our thanks.

Yours faithfully,

ADAM SKINNER.

Wolfson House,
1S12.

Thirty Years On

Dear Sir,

After thirty years of nationalisation the Health Service is in a state of near collapse with neither nurses nor doctors satisfied with the conditions of work and pay and patients although grateful, discontented. In the light of central Government's apparent inability to offer any positive solutions is it not time for local government to exercise its prerogative.

Where has the system gone wrong? There is no doubt that politicians, civil servants and all who administer the health service and its hospitals have worked with the good of the patients in mind. However, the technological and scientific advances have occurred too rapidly for them to be dealt with satisfactorily. It is understandable on this level that those involved with the health service in Britain have looked to America for guidance in modernising and replacing with new hospitals. At this stage it must be remembered that American hospitals are run under private enterprise while the nationalised service in Britain is controlled by a supreme bureaucracy. This has operated in the form of a dictatorship when dealing with available resources which have provided the finance for building new hospitals and for realising revolutionary techniques. The vital difference then between Britain and America in this respect is our total dependence upon limited financial resources. These are provided by the taxpayer but controlled by the Treasury.

In her autobiographical work "Matron of Guy's", Emily McManus underlined the dilemma and its implications. "Although I am a representative of the old-time voluntary hospital tradition, to me without doubt this complete change in the health service and in hospital administration, was inevitable and its advantages of financial security to the hospitals and health benefits to the nation, outweigh the *very real* drawbacks. a too heavy bureaucracy, a too remote control, a Treasury control *unlit by expert working knowledge of the subject,* a withdrawal of the privilege of initiative and a weakening of the personal touch."

Now thirty years on the situation can be assessed. That it has deteriorated rather than improved is plain for all to see. It seems that under Treasury control if the health service is to survive it must be the aim of all local governments, in view of their close involvement with the community, to provide solutions to the present problems. No time should be wasted in discussing the vast sums of money which have been squandered in such ill conceived schemes as the Liverpool hospital.

Members of the Royal College of Nursing in the reforms they have introduced have emulated American ideas, that of giving top jobs not to nurse educators but to those who have deserted nursing to hold jobs in administration. The question of how nurses should be educated and trained and who should be doing the job is today of prime importance in view of the changing scene now that hospitals can no longer be sure of a stable work force, but are dependent on part-time staff. Male nurses have introduced a new dimension into nursing but their value is not 100% as their experience in the field of children's. gynaecological and midwifery nursing is of a theoretical rather than a practical nature. Their value in administrative posts in Britain is high because they can

provide management with continuity of service which female nurses are no longer prepared to do.

So today the wheel can be said to have turned full circle. Professor Anne Altschils ideas are the ideas which were practised in Britain's teaching hospitals in the 1920s. They were practised by nurse educators who worked alongside nurses in the wards teaching by example. The educators were nurses whose value business experts today have said they are unable to evaluate as they have no yardstick for costing dedication.

Yours faithfully,

E. M. GRANT, S.C.M.

Ruddigore

Dear Sir,

I was delighted to see that the "Operatic Society" (as it used to be called), is, once more, about to burst forth with "Ruddigore".

It brought back happy, not to say alcoholic, memories of the last time this was produced. In those days, we took the Fortune Theatre for a week and the then Chairman of the Governors was one of the scions of the brewery companies and provided the male chorus with a barrel of beer and the female chorus with a case of sherry. The combined effect was that the then producer, Bertie Templeton, threw down his baton in despair and abandoned the production which was taken over, I think, by Greenwood ("whitish ties chaps"). However, we managed to produce it in the end and all seemed to go well.

The following year, the year King George VI died, we produced Princess Ida but this was a financial disaster because in those halcyon days the whole country went into mourning for the death of the King and this coincided with our production. Luckily, Mr. William Mollison, the then Senior E.N.T. Surgeon, came to our rescue but it took a long time for the society to pay off this debt and thereafter we never went to one of the West End theatres again. I thought these comments might just be of interest to the Society, which I wish well for its forthcoming production.

Yours faithfully,

J. C. JENKINS.

2 Burlington Road,
Leicester, LE2 3DD.

Sisters on beds

Sir,

The beds in the hospital are gradually being replaced by new Kings Fund beds at the cost of £220 per bed. Bed tables which cost £30 each are also being bought. These beds are very convenient and easy to use for the nursing staff, but the old beds were quite adequate; there was nothing wrong with them. The old beds are being thrown on the scrap heap.

In these times of shortage of money in the N.H.S., we feel that this money could have been better spent.

Yours faithfully,

JULIA FABRICIUS,
PEGGY DOUGLAS.
Ward Sisters.

Miriam Ward,
Astley Cooper Ward,
Guy's Hospital,
S.E.1.

From SLICKER

Dear Sir,

Once again your magazine has not done anything untoward to provoke this disreputable company, however, you did publish the previous letter which is provocation enough. Slicker Publications' Literary Correspondent, Dai Uresis, has recently informed us of his top ten "Shortest Books in the World" and we therefore forward you a copy :

(i) Porters' Book of Work Schedules.
(ii) Doctors' Book of Overtime Pay Awards.
(iii) Suggested U.K. Holidays for Porters.
(iv) Nurses' Guide to Shopping at Harrods.
(v) N.H.S. Guide to Porter Arbitration.
(vi) Doctors' Private Telephone Calls.
(vii) Vacant Beds at Guy's.
(viii) Career Prospects in the N.H.S.
(ix) Unfilled Administrative Positions at Guy's.
(x) Quiet Pints in the Students' Bar.

And the last Shortest Book in the World: "Controversial Letters Published by the *Gazette*".

Yours faithfully,

SLICKER Publications.

Slicker Publications Ltd.,
Guy's Dental School.

SPORT

I received the following from our sporting correspondent Brian Bore who is at present away working in Brighton.

The Bore Ink Report

Here in windy Brighton, there is a new hazard facing the populace of retired and semi-retired folk. This danger to the community, as you will no doubt have heard, has far reaching consequences and poses a serious problem to those interested in problems. The recent mild weather has brought out of hibernation that most dangerous of beasts the jogger. Hundreds of these overstimulated animals can be seen taking to the streets every morning attempting to lift pounds of fat from heavy bellies. The creaking of old joints and the tearing of wasted muscles has become the Brighton dawn chorus. These joggers pose a serious sociological and psychosociological threat to the normally peaceful environment. The question is just how bad is the situation at the moment.

I posed this all important question to Councillor Maxwell Grunt. He said:

"This is an all important issue with lives at stake, and we must draw the attention of the public to the harm these joggers do. This sudden surge of interest is entirely the fault of the media machine, and possibly even a communist backed plot. For example this T-shirt bearing the slogan 'Jogging clears the sinuses' has a label in the back marked C. & A. I have it on the best authority that this is an abbreviation of the communist slogan 'chaos and anarchy!' The advertisement on the television encouraging exercise for those who are unfit suggests in a most salacious manner that better health will result in a fuller enjoyment of pleasures of the flesh. This is typical of a high level campaign aimed at the unsuspecting public. It is vital that we alert the highest authorities and act in a positive manner to prevent similar damage to that done by those dratted skateboards. I honestly believe that jogging is a more serious threat than even the most dangerous skateboarding trick recently popular until we acted, that was of course taking the dog for a walk on a skate board."

But just what is the damage done by these joggers? I talked to a distinguished doctor Seasmus O'Dammenblast, expert on industrial injury and salubrious part time wrestler.

"To liken these individuals to an army of killer ants would not be far from the truth, to my mind. But we must consider their vandalism, and that is the only word for it, from two points of view, firstly the damage done by them and secondly that done to themselves. The damage they do is incalculable in cost as they career in front of cars, barge past doddery pedestrians and steal milk from doorsteps. The harm they cause to themselves is suicidal. Not to mention the odd fracture, sprain, or bruise, we here in Brighton have a seventy per cent increase in ruptures, a forty-six per cent increase in bunions and large increases in the amounts of athlete's foot, fallen arches, slipped discs, exposure and frostbite. My own personal studies concerning the severe effects of jogging causing schizophrenia and impotence are giving grave cause for concern. But the most worrying aspect of this whole problem is the appearance on the scene of a new menace, the geriatric jogger. We keep having to rescue them from traffic islands and resuscitate their frail bodies. They are far more dangerous than normal joggers as many of them are slightly deaf and partially sighted and cannot hear or see the warning signs of danger. Also if they jog regularly they may live longer which is bad for my business."

So as you can see the Brighton joggers may be the start of a countrywide problem and the question is should we stop this jogging now before it is too late. A team of policemen with high velocity stun guns are awaiting the official go ahead to move in, as high level talks go on to decide if this is the right plan of action. The council promise an urgent decision by July and lets hope they made the right one.

Reported from Brighton by

BRIAN BORE.

THE *VIPERS* ON TOUR

The Vipers team was formed two seasons ago to accommodate the drunkards of the Hospital who wanted to "play" rugby but were unable to secure a place in any real side. They take the field as Guy's VI side but would be prepared to go lower.

The tour, set to start at 7.30 a.m. on Friday, 24th March, finally set course for Wigan at 9.00 a.m. By 9.05 a.m. several card schools had formed. The interesting countryside as we passed through the industrial centres of Britain was augmented by a critical and informative commentary by Geoff Pigot, who pointed out such exciting landmarks as Fort Dunlop and the Watford Gap service station. By 2.00 p.m. most were drunk and had lost their tour funds, Twomey had read and inwardly digested 200 pages of "Ellis & Kalne" (you do not become House Officer to the Dean for nothing!). Pigot assured us "it's not too far now boys" and this was to become a catch phrase for the rest of the tour.

After booking in half an hour late at our three (now one) star hotel, we took on a native guide, who contrived to get us lost within 800 yards. Now a whole hour late we arrived at our first match.

Vipers 10 v. Preston Grasshoppers 26

After the long journey Guy's were languished and their lack of vitality was expressed in their play. Preston scored twice in quick time and Guy's seemed demoralised; however, a Paul Silvester try converted by John Twomey brought a short-lived sparkle back to the side. Other inexplicable scoring movements by the Grasshoppers consolidated their lead in the second half. The Vipers only non-verbal reply was a late try in the corner by Howard Longton, our scrum half.

Guy's found their second wind in the bar aided by a Barclays Bank touring side and the splendid hospitality of our northern hosts. As the evening regressed an impromptu female strip tease artist performed (see picture). Pigot, stimulated by this sight, realised the full significance of his newly acquired puberty and spent the rest of the evening in dalliance with the *young* lady. Eventually a rescue party extracted him and the coach left for a further imbibition at the hotel.

Back row : *Jackson, Palmer, Singer, Twomey, Allen.*
Middle row : *Gough, Tewson, Underwood, Birtles, Brockelhurst, Keen.*
Front row : *Twining, Singer, Silvester, Strachan, Evans, Pigot.*

Saturday

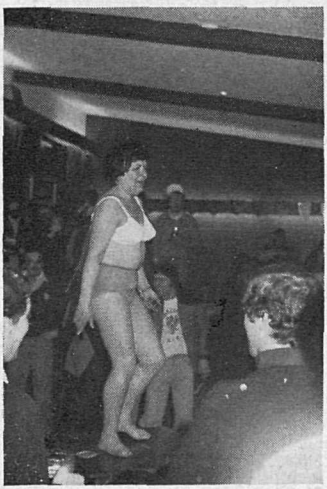
No match had been arranged. Over a hangover and breakfast a trip to Southport was arranged. Pete Twining, however, remained behind in an attempt to confirm that the quarter of a mile journey from the "Saracens Head" to the hotel could be made in anything less than the 4½ hours it had taken him the night before.

Pigot once again assured us that "it's not far" but took us on the "pretty" route. Southport proved not to be the mecca of the north, and Ashley Singer summed up the feelings towards Pigot by stating that if the opposition did not stand on him in the loose, he would. The slide was fun and the go-karts brought out the suicidal streak in Duncan Evans, but it was the roller coaster that led to Vern Allen's change of underwear and brought forth his true religious convictions.

Solids that evening were taken at a local Chinese restaurant. Guy Palmer proved his dexterity with prawn balls if not with rugby balls, eating a meal for six with chop sticks. Pete (Taff) Twining, who doesn't really like cider, had spent the entire day trying to rid the north of these stocks, joined us. In true Welsh spirit he launched into a song which turned out to be No. 63 on the menu when translated by Andy Strachan who always has spoken with a slanted nose.

Proving once again that cider has no effect on the taste buds Taff remonstrated with the orientals about the garlic which he felt sure contaminated every dish. Jackson was finally left to pay but found he had come out without his overdraft.

Back in the hotel bar an evening paper revealed the nature of our opposition for Sunday. This included two internationals and several county players. This caused much concern to one and all save Taff, who was so nonchalant that he even let a wall strike him on the forehead. No anaesthetic was required for the stitches. The last group of card sharps finally fleeced the local punters at 6.30 a.m. and all retired for the morning.



Geoff Pigot's tour friend
(Tour de force)

Sunday

The morning was spent following several pursuits. All the boys, however, met up in the "New Hotel" and drinks were consumed before heading off to the Saracens Head to meet our opposition. It was at this stage that we realised that one of the Saracens Head players was an old Guy's man (early leaver) by the name of Dave Robinson. After realising that the opposition were quite big we decided to send Howard Longton in first (burst of laughter from inside). Late afternoon saw us arrive at Wigan R.F.C. and it was only here that we realised that yet another dirty had been played on us—500 money paying spectators. The dressing room saw big match tension and Andy Strachan getting much maligned by Clive Archer when the latter was told he was playing prop. A hung over Guy's team took the field much to the amusement of the spectators and one lone Welsh voice (Taff) shouting "Vipers kill". Shortly after the kick off the Saracens Head took a 4—0 lead but this was soon eradicated by a Paul Keen try under the posts and a John Twomey conversion. Guy's 6—4 up. Some courageous tackling by all Guy's players especially Chris Jackson kept the Saracens Head well under control. A Pete Birtles interception between our 22 metres line and half way opened their defence and gave him a clear run. A magnificent dive saw him touch down but alas on their 22 metre line, much to the delight of the crowd. However, the Scottish international hooker Colin Fisher was not so amused and took his team to task. A renewed effort was noticed in their game and they quickly took control, under the direction of Sandy Service (West of Scotland scrum half). Guy's continued to play well but the only consolation was a penalty try when Pete Birtles was tripped just short of the line. John Twomey again converted. Despite a score of 40—12 in favour of the Saracens Head Guy's were complimented on their determination. After the match Pete Birtles was awarded man of match and required to drink a yard of ale which came up faster than it went down. Great hospitality was shown by the licensee Billy Burrows but the evening was soured by an unfortunate incident involving a member of the tour, which necessitated an apology on behalf of Guy's Hospital. Thankfully the apology was accepted and no animosity ensued. A cheque for £43 was given towards the Muscular Dystrophy Fund organised by the Thursday Club of the Saracens Head.

"We are Warriors"

Monday

Monday saw the last day of the tour with a liquid lunch partaken by all, and a great difficulty in raising a side. Our opponents on this day were Wigan and having been impressed by our Sunday performance they greatly strengthened their team by adding several former Lancashire Colts. Nick Singer typified the feeling of Guy's by leading us on to the pitch on crutches. A very weakened and tired side were completely overwhelmed and came second by a heavy margin (score unspecified). Watching from the warmth of the club house were Pigot, Jackson and Birtles all sporting fictitious injuries from the previous game (more convincing than the others!).

On the return coach journey our intrepid navigator Pigot got us lost within a mile of the club.

Our thanks go to Billy Burrows and Philip Santus who organised the Big match and to our coach driver Andy who put up with our navigator extremely well. After a dry journey the Wheatsheaf supplied much needed refreshment.

SOCCER

Promotion for the 1st XI

A dry and sunny day in Cobham witnessed the end of the soccer season for the 1st XI. By defeating the same K.C.H. team against whom the season had started last October, the runners-up position in Division One was clinched, and so assured us of the right to face the big guns of Bedford, University and Royal Holloway colleges next season.

The victory over King's was without doubt the finest moment of the season, a victory which was achieved with a remarkable comeback in a ten minute spell when all looked lost. The winning goal was slotted home by Mike Breeze with only a tantalising 30 seconds remaining. This too was one of our best performances: in goal Nick Cowland produced a superb reflex save in the 20th minute which boosted his confidence and that of the defence. Throughout the game Greg Tamlyn, playing for the last time for Guy's produced the beautifully timed biting tackles for which he has become renowned in Guy's football. Ken Harper had a game of reliable excellence as he has done so many times this season. Mark Batterburg, who has only gained his first team place in recent weeks demonstrated his strength of character by playing on after having been hit directly in the face by the opposing winger—a blow which went unpunished by the referee. This was particularly ironic as only five minutes earlier at the toss-up he had categorically announced his dislike for violence. What was needed at the time was a cool head

and the sense not to retaliate. Mark had both. Had the same happened to, shall I say, Neil Maclachlan or Greg Tamlyn, the pitch would have been a bloodbath. The midfield trio worked themselves to death on a pitch that was much bigger than we are used to, and they eventually dominated very capable opposition. The forwards, Dave Smalley, Paul Shepherd and Mike Breeze ran rings round a very square King's defence, only to be thwarted time and time again by the superb goalkeeping of Roger Cole. The scoreline of 2—1 was no reflection on the course the game had taken.

And so promotion was achieved: a goal which had looked a certainty at the beginning of the season, which started to look distant with atrocious games around the Christmas period, when eight points were dropped out of ten, and which was only made secure with an extremely good final run in. The team notched up six wins and two draws in the final eight games in this period.

The season began with a flourish: a fine performance against a strong City University team and consecutive high scoring league matches against R.S.M., Thomas' and Birkbeck set Paul Shepherd, Mike Breeze and Jon Earnshaw off in the race for the "top-scorer of the season" slot. The latter game earned no praise from our old friend Vernon "Jack" Frost who was reported to have said that we played "like West Germany"—or was it West Drayton? Before I dismiss this as the most ridiculous comment of the season—Jack Frost is no Helmut Schoen, and in the game he refereered he ably demonstrated that he scarcely knew the rules—let me say that at the time players were fit, and the football was neat, fast and confident.

We progressed towards Christmas and the pace disappeared from our game. We bowed out of the U.L.U. Cup to Imperial College, having led 2—0 for 75 minutes of the game, but eventually losing 6—2 after the most devastatingly effective substitution of all time. Apologies. Mistakes are always learnt from. Disastrous performances against S.O.A.S. and Chelsea College slowed us up in our race for a league position, and the Christmas break was greeted with dispondency. Nor did the picture change much following the holiday: an 8—0 victory over a weak Icarno team only made us complacent, and we went down at home to Mary's, and King's, struggled against Thomas' but put in a fighting performance against the London in the U.H. Cup quarter final. We lost 3—2 to underhand London tactics, a feature of their game that too many Guy's teams have suffered from for too long. But, I have to admit that underhand tactics can prove to be effective, and when all is said and done it's the winners who get the glory and not the gentlemen.

After that time we never looked back and fought our way with determination to the King's game in Cobham which was to decide the league fate of both teams. Along the way mention must be made, I think, of an un-named Guy's referee who awarded a penalty against an un-named Guy's player in a game in which points were crucial. Had the resulting goal proved more costly I may not have been so benevolent, but let it suffice to say now that I am delighted to see that sportsmanship really does exist!

At the end of this article there is an analysis of the season. It indicates the remarkable performance of Paul Shepherd in scoring almost a third of our season's tally of 107 goals. Undoubtedly he had benefited from playing U.H. football this season. His ability to hit the back of the net from any angle or position is quite incredible. I think also that he may have learnt, from a single nail-biting moment in the King's game, a lesson which will stand him in good stead for next season's penalty taking. Mike Breeze has also netted 25 times, and hit some magnificent right-foot volleys. His form has fluctuated this season, but he retains the potential to turn it on when needed, and leave full-backs bemused with speed and ball control. Jon Earnshaw has been a stalwart of the football club now for many seasons, and I admire the tenacity with which he held on to his first team place for so long. He scored nineteen times, and among them there were memorable goals: one, a header which he flew through the air to reach, and another a sizzling volley which he produced from nowhere. Jon is the sort of personality the football club could not do without, and his great worth lies in his willingness to give 100% effort every game he plays. Dave Smalley increased his confidence with every game. Although often out of position he has showed remarkable adaptability which was born of his keenness to play.

Simon Perkins and Ian Wilson are the mainstay of the midfield. Both are tireless, skilful and aggresive players with very characteristic styles of play, the ability to distribute the ball superbly and produce goals at vital moments. Their experience of Premier Division football will be invaluable to next season's team, which will be composed most likely of

young players. Dave Rees—another very skilful player, has suffered this season both from injury and the competition that has existed for places. It is to his credit that he has always been prepared to play when needed.

Tribute must be paid to Greg Tamlyn who has served Guy's football well for many seasons. The team will miss that rare touch of violence which frightened referees as well as centre forwards, and probably made him Guy's most expensive player. All good entertainment. For most of the season he has anchored the defence. In his absences he has been ably deputised for by the solid Dave Abraham. Neil Maclachlan has been in the team almost constantly, and his "combined - harvester" tackling which mashes wingers to pulp has undoubtedly been a source of consternation for opponents, but has been one of confidence for the defence. At right back Ken Harper has established himself in a position that must be his alone for a long time to come. Who knows what he might accomplish if he lost his beer-gut!

And what of the younger players? Nick Cowland, Mark Batterburg and John Rawcliffe are good prospects for Guy's football for seasons ahead. Nick has been almost ever present in the first team in this, his first year at Guy's. On his own admission he has learnt a lot and has a lot to learn, but the evidence of the fine saves that he has made indicate that with a little more confidence he can become a very good goalkeeper. Mark Batterburg is a good, constructive player with determination. A little more application and John Rawcliffe could develop into the left winger the club needs.

So, now we can look forward to next season; a season that will see Guy's with a team in the University Premier Division, a second XI that by the time this goes to press ought to have been promoted from Division 3R, and a third team which has already been nominated for entry into the league. There are lessons we ought to have learnt from our last brief encounter with Premier Division football, and I hope they are applied to ensure that our stay is a little longer. Next season we can also look forward to a tour to Holland which already has groundwork laid.

At last we can quite rightfully lay claim to some of the area at H.O.P. wasted by the Hockey Club, and it is heartening to see that hitherto appalling training facilities afforded Guy's sport are being improved with the introduction of a hopefully floodlit all-weather surface. At this point I would like to thank Mr. Eric Dunn on behalf of the football club for the support he has given us this season. The pitch has invariably been in excellent condition, the kit always clean and shandies and hot baths have always awaited us at the end of a game. Thanks must also go to Roger Davies, their Secretary, who has worked so efficiently, to Gerry Hackett who has refereed often, and not least to Professor Robinson who has taken an active part in the club in his first year of presidency.

While Rugby Club members argue out their own domestic problems, the Hockey Club continues in its anonymity, and other clubs struggle to stay alive in the face of overwhelming apathy, it is with pride that I can say that the Soccer Club is enthusiastic and thriving, and destined for further success. It has been my pleasure to captain it this season.

ANDREW MITCHELL.

League Analysis

Played 18, Won 12, Drawn 2, Lost 4. Points 26. Goals: For 76, Against 42. Position: Runners-up.

Total Analysis

Played 26, Won 15, Drawn 3, Lost 8. Goals: For 107, Against 66.

Goals

P. Shepherd (30), M. Breeze (25), J. Earnshaw (19), I. Wilson (9), S. Perkins (8), D. Lamb (4), A. Mitchell, D. Smalley, D. Rees (2), D. Abraham, C. Archer, J. Rawcliffe, L. Broughton, R. Agwithe, O.G. (1).

Appearances

A. Mitchell (26), N. Cowland (25), I. Wilson (24), P. Shepherd (23), K. Harper (22), S. Perkins (21), J. Earnshaw, N. Maclachlan, M. Breeze (20), D. Smalley (17), G. Tamlyn (16), D. Abraham (13), D. Rees (12), D. Lamb (6), M. Batterburg (5), J. Rawcliffe (4).

CAMBRIDGE SQUASH TOUR

On the weekend of the 11th March, "Guy's Gonads" squash team travelled to Cambridge for a tour.

In our first match on the Friday evening only four of the five man team were present because Victor Tun was allegedly dancing in Liverpool. However, the match was closely fought in all games. Jamie Farquharson turned out to be our only winner. Nick Higgins surprised us all by only arriving two hours late, claiming he thought the tour was in Oxford.

On the Saturday we only had one match in the afternoon which meant that the morning was free. We decided that it was time to turn our talents to a game of tennis and Frisby throwing, such was the state of the weather.

The match in the afternoon was against our hosts St. Johns, who narrowly defeated us by three games to two. Jonathan Pringle and Victor Tun both winning their games, the former winning despite his illusion that he was still on the tennis court.

In the evening we attended a masked party which eventually turned into an unmasked party.

On our final day the match was against Caius who were considerably weaker than our previous opponents. Jamie Farquharson won easily dispelling all rumours that he was "passed his best". Victor Tun however, still seemed to think he was in Liverpool and was narrowly beaten by an elderly opponent.

Although we only won one match out of three the Squash tour was considered to be an immense success. I don't think there was one of us who would have minded repeating the Tour the next weekend.

The team consisted of Jamie Farquharson, Victor Tun, Jonathan Pringle, Nick Higgins, James Murch.

JAMES MURCH.

HOSPITAL INFORMATION

PAPERS BY GUY'S MEN

Adinolfi, M. and Haddad, S. A. (1977). *Levels of Plasma proteins in Human and Rat* fetal CSF and the development of the blood-CSF barrier. **Neuropadiatrie, 8,** 345-353.

Alberman, E. and Creasy, M. (1977). Frequency of Chromosomal abnormalities in *miscarriages and perinatal deaths.* **Journal of Medical Genetics, 14,** 5, 313-315.

Alberman, E. (1977). *Facts and Figures.* In: Benefits and Hazards of the New Obstetrics. Charted, T. and Richards, M. **Eds.** pp. 1-17. **Spastics International Medical Publications.**

Buisseret, P. D., Pembrey, M. and Lessof, M. H. (1977). α-antitrypsin phenotypes in rheumatoid arthritis and ankylosing spondylitis. **Lancet, II,** 8052/3, 1358-1359 (Letter).

Seller, M. J. (1977). Dark brown amniotic fluid. **Lancet, II,** 8045, 983-984 (Letter).

Alberman, E. (1978). Fertility drugs and Contraceptive agents. In; Scrimgeour, J. B. **Ed.** Towards the prevention of Fetal Malformation. pp. 89-100. Edinburgh: **Edinburgh University Press.**

Cook, P. R., Brazell, I. A., Pawsey, S. A. and Giannelli, F (1978). Changes induced by ultraviolet light in the superhelical DNA of *lymphocytes from subjects with Xeroderma* pigmentosum and normal controls. **Journal of Cell Science, 29,** 117-127.

Perrine, R. P., Pembrey, M. E., John, P., Perrine, S. and Shoup, F. (1978). Natural History of *Sickle cell anemia in Saudi* Arabs. **Annals of Internal Medicine, 88,** 1, 1-6.

Polani, P. E. (1978). Future developments in Antenatal screening and Diagnosis, In: Scrimgeour, J. B. **Ed.** Towards the prevention of *Fetal Malformation. pp. 261-272. Edinburgh:* **Edinburgh University Press.**

Stirling, J. L., Robinson, D., Fensom, A. H., Benson, P. F. and Baker, J. E. (1978). Fluorimetric assay for the prenatal diagnosis of Hurler *and Scheie homozygotes and heterozygotes.* **Lancet, I,** 8056, 147.

Amlot, P. L. and Green, L. A. Atopy and immunoglobulin E concentrations in Hodgkin's disease and other lymphomas. **British Medical Journal,** 1978, **1,** 327.

Barnes, T. R. E., Kidger, T. and Taylor, P. J. On the use of dopamine agonists in tardive dyskinesia. (Letter.) **American Journal of Psychiatry,** 1978, **135,** 132.

Binnie, W. H. et al. [The role of xeroradiography in cephalometric radiology]. (Letter.) ***Journal of Dentistry,*** *1977,* **5,** 294.

Brewin, T. B. When and how should we teach the basic concepts of radiation beam dosage? **British Journal of Radiology,** 1977, **50,** 430.

Brewin, T. B. The cancer patient: communication and morale. **British Medical Journal,** 1977, **2,** 1623.

Buisseret, P. D. Common manifestations of cow's milk allergy in children. **Lancet,** 1978, **1,** 304.

Burn-Murdoch, R. A., Fisher, M. A. and Hunt, J. N. The slowing of gastric emptying by proteins in test meals. **Journal of Physiology,** 1978, **274,** 477.

Dixon, M. Bran and HDL-cholesterol (Letter.) **British Medical Journal,** 1978, **1,** 578.

Fernow, L. C., McColl, I. and Mackie, C. Firm, patient and process variables associated with length of stay in four diseases. **British Medical Journal,** 1978, **1,** 556.

Frankland, A. W. Respiratory disease associated with practolol. (Letter.) **Lancet,** 1978, **1,** 329.

Gardiner, P. Identifying poor vision. **Health and Social Service Journal,** 1978, **88,** 256.

Goulding, R. and others. Household products *and poisoning.* ***British Medical Journal,*** 1978, **1,** 286.

Goulding, R. When did you last ring the Poisons Information Service? **Modern Medicine,** 1978, **23** (2), 62.

Hiiemae, K. M. et al. A radiographic and electromyographic study of snapping and biting *in the oppossum.* **Archives of Oral Biology,** 1977, **22,** 303.

Hughes, R. A. C. Immunological aspects of *multiple sclerosis.* **British Journal of Hospital Medicine,** 1977, **18,** 467.

Jarrett, R. J., Viberti, G. C. and Al Sayegh, H. Does "afternoon diabetes" predict diabetes? **British Medical Journal,** 1978, **1,** 548.

Jefferys, D. B. and Vale, J. A. Effect of cimetidine on glucose handling. (Letter.) **Lancet,** 1978, **1,** 383.

Joseph, M. Rapid calculation of children's fluid requirements after cardiac surgery. (Letter.) ***British Medical Journal,*** *1978,* **1,** *306.*

Mace, M. C. Condylar metastosis from mammary adenocarcinoma. **British Journal of Oral Surgery,** 1977/78, **15,** 227.

Mackenzie, C. Paranoia is the norm and serenity unusual. **Health and Social Service Journal,** 1978, **88,** 220.

Minton, M. J., Cantwell, B. M. J., Knight, R. K., Rubens, R. D. and Hayward, J. L. Safety of tamoxifen. (Letter.) **Lancet,** 1978, **1,** 396.

Montgomery, S. and others. Differential effects on suicidal ideation of mianserin, maprotiline and amitriptyline. **British Journal of Clinical Pharmocology,** 1978, **5,** supplement 1, 77S.

Montgomery, S. and others. Relationship between mianserin plasma levels and antidepressant effect in a double-blind trial comparing a single night-time and divided daily dose regimens. **British Journal of Clinical Pharmacology,** 1978, **5,** supplement 1, 71S.

Pembrey, M. Genetic counselling and prenatal diagnosis: what we need to know. **Modern Medicine,** 1978, **23** (2), 65.

Pepper, J. R. Thoracopy in the diagnosis of pleural effusions and tumours. **British Journal of Diseases of the Chest,** 1978, **72,** 74.

Ponz de Leon, M., Murphy, G. M. and Dowling, R. H. Physiological factors influencing serum bile acid levels. **Gut,** 1978, **19,** 32.

Rees, R. J. W. and others. A study of alleged leprosy bacillus strain HI-75. **International Journal of Leprosy,** 1977, **45** (2), 101.

Rees, R. J. W. and others. Correlation of euglobulin immunoglobulin G levels with erythema nodosum leprosum in lepromatous leprosy. **Clinical Immunology and Immunopathology,** 1977, **8,** 335.

Rees, R. J. W. and others. Dapsone alone compared with dapsone plus rifampicin in short-term therapy of lepromatous leprosy. **Leprosy Review,** 1977, **48,** 223.

Rees, R. J. W. and others. Naturally acquired leprosy-like disease in the nine-banded armadillo (dasypus novemcintus): reactions in leprosy patients to lepromins prepared from naturally infected armadillos. **Journal of the Reticuloendothelial Society,** 1977, **22** (4), 369.

Rees, R. J. W. and others. Rifampicin for lepromatous leprosy: nine years' experience. **British Medical Journal,** 1978, **1,** 133.

Symmons, J. The hazards of the dental aerosol. **Dental Update,** 1977 **4** (8), 467.

Webb, J. Severe hypercapnia associated with a non-respiratory alkalosis. **British Journal of Diseases of the Chest,** 1978, **72,** 62.

JUNIOR LECTURER IN THE DEPARTMENT OF MEDICINE

Applications are invited for the post of Junior Lecturer in Medicine for one year. The person appointed will have the duties of a Senior House Physician, be responsible for some of the academic and curricular activities of the department, and will have an opportunity of collaborating in research.

Salary will be as for an SHO in Medicine.

Job description and application form may be obtained from and should be returned to the Dean, Guy's Medical School. Closing date for applications is 18th May, 1978.

Applications are invited for the following Scholarships for the Session 1978-79. Forms are obtainable from the Dean and should be returned not later than 29th May, 1978.

The Beaney Scholarship in Materia Medicine

Candidates for the Scholarship must have received part at least of their medical education at Guy's Hospital Medical School. The object of the Scholarship is to advance knowledge of Materia Medicine (including Pharmacy, Pharmacology and Therapeutics) by supplying the Scholar with the means of carrying out original investigation in these subjects. The Scholar holds the Scholarship for three years and is eligible for re-election. The Scholarship is of the annual value of approximately £500.

The Arthur Durham Travelling Studentship

Candidates for the Studentship must be registered medical practitioners who have studied at Guy's Hospital Medical School. The Student is required to proceed abroad for the purpose of carrying out such investigations as may be approved or directed by the Board of Electors, and shall undertake to reside continuously abroad for a period of not less than six months. The Studentship is of the value of approximately £525.

The Sir Alfred Fripp Memorial Fellowship

The Sir Alfred Fripp Fellow is required to promote the advancement of knowledge and research in Psychology, more particularly through the study of children in health and/or disease. The Fripp Fellow is allowed opportunities for study in the Department of Paediatrics and the Department of Child and Adolescent Psychiatry and is required to submit with his or her application a definite scheme of advanced study or research to be carried out during the tenure of the Fellowship. The Fellowship is ordinarily for a period of two years but may be renewed for a further period of up to three years. Candidates must possess a registrable medical qualification and should not be more than 35 years of age. The value of the Fellowship is up to £1,220 per annum according to the seniority of the holder and the amount of time to be devoted to the Fellowship.

Dr. James Leighton Hopkins Travelling Scholarship

Candidates for the Scholarship must be registered Medical Practitioners, who have Scholar to travel to gain further experience. mately £775.

The Francis Lett Scholarship

Candidates for the Scholarship must have The value of the Scholarship is up to approxistudied at Guy's Hospital Medical School. The purpose of the Scholarship is to assist the studied at Guy's Hospital Medical School. The Scholarship may be held by itself or in conjunction with other Studentships. The purpose of the Scholarship is to enable the Scholar to obtain experience in other Medical Schools or Hospitals, at home or abroad. Candidates must submit their proposed programme with their application. The Scholarship is of the value of up to approximately £1,000.

The Hilda and Ronald Poulton Fellowship

The Poulton Fellow carries out research in the Department of Medicine under the direction of the Professor of Medicine and the object of the Fellowship is to increase the knowledge of the origin, progress, treatment and cure of obscure diseases in man. The Fellow is appointed for two years in the first instance with possible reappointment from year to year. He is required to work at least half his time in the Department of Medicine under the direction of the Professor of Medicine and may hold another appointment at the Hospital or School. The present value of the Fellowship is approximately £450 per annum.

The Adrian Stokes Memorial Fellowship

The Fellowship is open to registered Medical Practitioners or Graduates in Science, Pathology, or Bacteriology. Applicants must be anxious to carry out further study in Pathology or Bacteriology in any of their branches. The Fellow is required to carry out this study during a period of not less than six calendar months in his year of tenure at a University, School or Hospital, or other institution, subject to the approval of the School Council, except the School in which he has received his medical or scientific education. The Fellowship is of the value of approximately £1,100.

CHANGES OF ADDRESS

Dr. and Mrs. J. B. Franklin, "Boveys", 16 West Park, South Molton, N. Devon, EX36 4HJ. Tel. South Molton 2237.

Surgeon Commander (D) and Mrs. E. J. Grant, 15 Monckton Road, Alverstoke, Gosport, Hampshire, PO12 2DG. Tel. Gosport (07017) 23339.

Dr. and Mrs. W. B. D. Maile, Prinsted Grange, Prinsted, Emsworth, Hants. Tel. Emsworth 2017.

Dr. and Mrs. Andrew Seal, 201-2475 York Avenue, Vancouver, British Columbia, Canada, V6K 1C9.

Dr. Richard Sharp, Teignlawn, Forder Lane, Bishopsteignton, Teignmouth, Devon. Tel. Teignmouth 6186.

PERSONAL

A VACANCY will occur in late June for an associate with a view to partnership in an old established dental practice in Exeter. It would suit an applicant who would wish to perform high quality conservative treatment in a happy working environment. Box No. 3/78.

W.E. ENGINEERING, 210-211 Carter Place, off Walworth Road, S.E.17. Tel. 01-701 5594. Car and Commercial Repairs. Servicing and repairs of all cars. Cars left in the morning before work will be ready in the afternoon.

TIM HOPE-WYNNE, an established Life Assurance and mortgage advisor with Imperial Life Assurance Company of Canada, has been visiting and advising doctors and nurses at Guy's about their financial circumstances in relation to these matters. If you feel you would like his help contact him on 01-937 7292.

CENTRAL EXAMINING BOARD FOR DENTAL HYGIENISTS

Certificate of Proficiency in Dental Hygiene

March 1978 Examination

Miss H. I. Bridge
Miss W. J. Burch
Miss F. De Wet
Miss A. E. Hopkins
Miss A. M. O'Flaherty
Miss J. A. Partington
Miss C. Pietrzak
Miss J. E. Purdy
Miss E. A. Ritchie
Mrs. L. R. Wake
Miss A. E. C. Wells

F.R.A.C.P. 1977

J. F. Hallpike

BIRTHS

SEAL—To Hilde (née Servaty) and Andrew Seal on 24th January, 1978 at the Grace Hospital, Vancouver, British Columbia, a son, Alexander, a brother for Natalia.

SHARP—To Jenny and Richard Sharp on 7th October, 1977, a third son, Andrew Edward Cowper.

DEATHS

On 12th February, 1978, Mr. P. G. Sparg, LDS, RCS, of Sinclair-Smith Dental Clinic, East London, R.S.A.

We should like to remind our readers that all copy for inclusion in the "Gazette" must be received 12 days before publication. Copy dates for the next 3 months are: 15th May, 12th June, 17th July.

Copy may be sent to us at 16, St. Thomas Street, S.E.1.

Birth, Marriage, Death and Change of Address notices are inserted without charge to subscribers.

When subscribers notify the "Gazette" of Change of Address, would they please indicate whether or not this should be published.

Personal notices are charged at 10p per word (pre-paid, minimum £2.00).

Non-subscribers are charged £2.00 (pre-paid) for all notices other than Death.

GUY'S HOSPITAL GAZETTE

ISSN : 0017-5870 Tel. No.: 01-407 7600 Ext. 2023

EDITOR ADRIAN PINI
ASSISTANT EDITOR PHILIP RAZZELL
NEWS EDITORS STEPHEN FENNY and CAMILLA HAW
SPORTS CORRESPONDENT JONATHAN EARNSHAW
NURSING CORRESPONDENT PAMELA JEFFERIES
PHYSIOTHERAPY CORRESPONDENT RONALD COOPER
RADIOGRAPHY CORRESPONDENT JILL GUEST
MANAGER LYN PAYNE

MONTHLY 27 MAY 1978 VOLUME 93 92 NUMBER 2282

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

The decision by Southwark Council to throw out the planning application of 70 Guy's consultants to build a private hospital at Chamberlain's Wharf because it "might prejudice later development of the area" is perhaps to be expected from a council supporting a government intent on doing away with private practice. Cllr. Ron Watts said that he welcomed any application which involved renovating an old building, but was worried about the private hospital's "effect on future land use allocations".

Over the last three years 106 hospitals have closed and the waiting list is now estimated to be in excess of 590,000. Hospital closure and the ideology of phasing out 1,356 paybeds have clearly failed to cut the queues and failed to ameliorate patients' and the medical profession's discontent. One of the most widely held objections to private practice is that it enables the rich to obtain privilege over matters of human rights. I should be inclined to agree but only if it can be shown that existing private practice acts to the *detriment* of those not receiving it and I have yet to see a convincing case that it does, although it is of course indicative of a sick health service.

Over this issue there is as much fire as there is muddled ideology. Pretty well everyone in this country would be against the American type system of cheque book health care where there is little doubt that cash buys health (and the diseases of affluence), but I fail to see how (justified) arguments against the American system can help us; they are simply inappropriate. The sour grapes of misplaced attack is understandable though it can do nothing except perpetuate its own malcontent.

If the Government spent as much on the N.H.S. as it seems to think fit on our obsolete nuclear "deterrent" private practice *as we know it* would disappear.

NEWS IN BRIEF

Dates from the Medical Diary

Monday, 29th May—BANK HOLIDAY—Medical School Office closed.

Tuesday, 30th May—Entries close for the Final Conjoint Examination in June.

Monday, 5th June—M.B., B.S. (Revised Regulations) Examinations begin. Final Cambridge M.B., B.Chir. Examinations begin.

Monday, 19th June—Preliminary Examination for Studies in Medical Subjects begins.

Monday, 26th June—Final Conjoint Examination begins.

Dates from the Dental Diary

Monday, 29th May—BANK HOLIDAY—Medical School Office closed.

Tuesday, 30th May—Final L.D.S. Examination, Part III begins.

Wednesdal, 31st May—The Malleson Prize for Dental Students' Research—reports must be submitted not later than this date.

Friday, 9th June—Written paper for the David Frank Sturdee Prize in Prosthetic Dentistry and the Properties of Dental Materials.

Monday, 12th June—N.B. Second B.D.S. Examination may begin this week or next week.

Monday, 19th June—Third B.D.S. Examination, Parts I, II, III, IV and V begins.

Monday, 19th June—N.B. Preliminary Examination for studies in Medical Subjects may begin this week.

Issues in Health Group

Wednesday Afternoon Seminars

The Issues in Health Group are presenting a series of fortnightly seminars every alternate Wednesday afternoons beginning at 1.30 p.m. The theme running through the series is "Health and the Community".

Wednesday, 31st May, 1.30 p.m. "Community Psychiatry". Speaker: Chris Higinbotham, Chairman Camden Gateway.

Wednesday, 14th June, 1.30 p.m. "The work of the Unit for the Study of Health Policy." Speaker: Dr. Peter Draper, Director, Unit for the Study of Health Policy.

All the seminars will take place in the North Common Room, Boland House, Guy's Hospital.

Department of Post Graduate Studies, Diary

Tuesday, 30 May

8.30	X-ray Departmental Meeting in X-ray Dept., 3rd floor, Guy's Tower.
11.45	Gastroenterology Triangular Meeting—radiologists, histopathologists and clinicians. Demonstration Room, 2nd floor, New Guy's House.
1.00	New Cross Hospital: Clinical Meeting in the Side Ward off Bedford Ward.
5.30	Neurology/X-ray Meeting in X-ray Dept., Guy's Tower.

Wednesday, 31st May

12 noon Rheumatological/Orthopaedic Case Conference followed by:

1.00 Rheumatology Meeting—subject to be announced—Nurses Lecture Room, New Cross Hospital.

12.15 Renal/X-ray Meeting in X-ray Dept., 3rd floor, Guy's Tower. Dept. of Nuclear Medicine Case Discussion in Dept. of Nuclear Medicine Library.

1.00 Cardiac Dept. Meeting.

5.00 Department of Medicine Clinical Meeting—Case presentation by the neurologists in Neurology Demonstration Room, ground floor, Hunt's House.

5.00 Dept. of Surgery meeting in Demonstration Room, 2nd floor, New Guy's House.

5.30 Dept. of Anaesthetics in Clinical Lecture Theatre, 2nd floor, New Guy's House—a talk by Dr. Penelope Key from the Ministry of Overseas Development—subject to be announced.

Temporary Closure of Medical Wards—Hunts House

Urgent work to be carried out in Miriam and Stephen Wards necessitates the following arrangements.

Monday, 5th June—Close Wilks and Miriam Wards to all admissions. Transfer patients back to their parent wards.

Tuesday, 6th June—Re-open Wilks/Miriam/Stephen Wards for all admissions.

These will be subject to confirmation.

Prizewinners

Gilbert Prize in Rheumatology.
—P. J. Howard.

Beaney Prize In Immunology.
—Miss M. E. Ganczawkowski.

Richard Ellis Prize in Paediatrics.
—Miss D. M. Mitchell.
Certificate of Merit—N. C. G. Bathurst.

Gillespie Prizes in Psychological Medicine.
Awarded jointly: —N. Joyner.
Miss T. J. Leverton.

Beaney Prize in Histopathology.
—L. N. Denmark.
Certificate of Merit—B. D. Edwards.
A. Jacks.
Miss M. E. Ganczakowski.

Exhibitions at the Victoria & Albert Museum

Currently showing (May 31st until September 10th) in Rooms 70-73 are the drawings, photographs and prints of Sir Gilbert Scott, representing his thirty year period (including the Gothic revival) and marking the centenary year of his death.

"Max"

We regret to hear that Mr. Wheeler's dachshund, kennel name "Courteous Camelot", better known to staff and friends as "Max", died in the School last month.

NOTICES

Service for Miss Emily E. P. MacManus

A service of Thanksgiving for the life and work of Emily E. P. MacManus, C.B.E., 1886-1978, Matron of Guy's Hospital 1927-1946 will be held in Southwark Cathedral on Monday, 5th June, 1978 at 12 noon.

The Communion Service arranged for members of the Guy's Hospital Nurses' League will take place as previously notified.

Dennis Deuchar Memorial Prize Award

The appeal for the Dennis Deuchar Fund is now closed and the Governors of the Medical School have agreed to set up a fund which will permit the award biennially of a Dennis Deuchar Memorial Prize. The prize will be awarded to a medical student wishing to spend an elective period abroad and preference will be given to applicants wishing to study cardiology.

CLUBS' UNION NEWS

This month's Clubs' Union News *is devoted to an analysis of the recent grants announcement by the Department of Education and Science (DES) and its implications for* members of *the Clubs' Union.*

Next year Medical and Dental students in London will receive quite substantial increases in their grants. The rate for the first 30 weeks of the course (known as the "main rate") will rise by 14.8% to £1315 and the additional grant for extra attendance will be increased by 20.8% to £27.55 per week. The main rate for students living with their parents will rise by 10.8% to £870 and the grant for the extra weeks will be increased by 18.1% to £12.75.

The grants for this year and next year for various course lengths are set out in the table below.

Students living in Hall/Lodgings	Length of Academic Year (weeks)	Grant for 1977/8 £	Grant for 1978/9 £	% Increase
	30	1145	1315	14.8
	33	1213.40	1397.65	15.2
	40	1373.00	1590.50	15.8
	52*	1646.60	1921.10	16.7
Students living at Parental home				
	30	785	870	10.8
	33	817.40	908.25	11.1
	40	893.00	997.50	11.7
	52*	1022.60	1150.50	12.5

*If the length of the academic year is 45 weeks or more a 52 week grant is awarded.

The cost of board and lodging in London has always been greater than in the provinces thus London students are receiving a larger increase to ease the financial strain which has built up over the last few years. For example, the main rate for London has increased by 14.8% whereas the main rate for the provinces has increased by 8.9%. While the weekly rate for extra attendance has increased by 20.8% in London, the increase for the provinces is only 11.5%. The reason for this is that the additional grant is almost solely made up of the notional element in the main rate for board and lodgings and this is considerably less in the provinces.

It can be seen from the above figures that, despite these generous increases, the weekly rate for clinical students is still less than the weekly rate for preclinical students.

Shirley Williams (the Secretary of State at the DES) in a recent communication set out the reason why only the board and lodging element is included in the extra weeks payment.

"On the question of the adequacy of the rate of grant for extra weeks' study, there seems to be no reason why expenditure relating to the course as a whole, which is provided for in the main grant—for example on books and equipment—should be increased by a student's study outside normal term time."

From this statement it is obvious that the DES misunderstands the position of those on long course grants such as clinical medics and dentists.

The effect of working an extra eighteen weeks in a year is to condense into two years what would otherwise be three years work. Consequently, a proportionately higher expenditure is incurred on books, stationery, equipment, clothing, personal travel etc. This additional expenditure is not reflected in the extra weeks payment which comprises only the notional element for board and lodging.

A government survey conducted in 1974/5 showed that students had to spend on living costs more than was provided for in the student grant. To balance budgets they spent less on course costs than was provided for in the grant. Setting the extra weeks payment at such a low level exacerbates this problem for long course students who have no opportunity to supplement their term time income by working in the vacation.

Most students at Guy's will receive an award from their Local Education Authority (LEA) and their parents will have to contribute a certain amount depending on their residual income (calculated by a means test) to make up the full grant. The threshold for the parental contribution will be raised and the parental contribution will be scaled down. The degree to which it will be reduced depends on parental income. The minimum grant will increase from £80 to £200.

The government survey referred to above showed that 73% of students not receiving a full grant from their LEA did not have their grant made up to the full amount by their parents. This is only one of the many ugly facets of the means test system. For purely financial reasons many potential students choose to go out to work rather than pursue a course in further or higher education after leaving school because they do not wish to be dependent on their parents. Thus the reduction of the parental contribution is a step in the right direction *towards the eventual abolition of the means test.*

The clinical student works for 48 weeks of the year with four weeks vacation. The threshold at and above which the 52 week grant is awarded is 45 weeks, thus clinical students should receive a 52 week grant.

However, some first year clinical students may not have received a 52 week grant this year due to another anomaly in the grants regulations. The DES academic year, for grant-awarding purposes, runs from September 1st to August 31st and, according to a strict interpretation of the regulations, the grant is awarded for the number of weeks in attendance between these two dates. Thus a course commencing in the first week of October is a 48 week course in DES terms and taking away the four weeks holiday of a clinical student brings the length of the academic year (for grant purposes) down to 44 weeks, which is below the 45 week threshold. Most LEA's interpreted the regulations liberally and gave first year clinical students the 52 week grant (£1646) but some, for the above reasons, gave them a 44 week grant (£1464.20)—a substantial difference of nearly £182.

The attention of the DES has been drawn to this anomaly and it is hoped that they will rewrite the relevant section of the grants regulations to enable all first year clinical students to receive a 52 week grant.

The special equipment grant for medical students will be increased from £40 to £49. This is a grant awarded for the whole of the course for items such as dissecting kits, white coats, stethoscopes, and so on, and the increase will apply not only to students commencing their studies next October but also to those continuing their studies next year.

Although according to the regulations Dental students are not eligible for this grant some have been successful in claiming it from their LEAs, and are therefore advised to claim for special equipment. Dental students are lucky to be given a lot of expensive equipment *gratis* but still have to spend extra amounts on maintaining that equipment and buying other items of special equipment. They deserve, for these reasons, to be given an equipment grant which covers this additional expenditure.

The National Union of Students will be conducting a survey of Medical and Dental students expenditure to assess, amongst other things, the amount spent on special equipment, because there is general feeling that the special equipment grant is too low.

At present the Local Education Authority will pay the cost of travel over a threshold of £32; this threshold will be raised to £34.

This year some LEAs were unwilling to pay for the cost of travelling between Guy's and other hospitals because they were not regarded as being part of the same educational institution. Next year the LEA is bound to reimburse the cost of travelling between Guy's and other hospitals.

If there are any questions about this article or the grant system in general please write them down and put them in the Clubs' Union pigeonhole and we will endeavour to answer them as fully as possible.

Philip Carney.

QUODLIBET SOCIETY

Arthur Scargill on "The Current Situation"

Tuesday, 9th May, 1978

Arthur Scargill, President of the Yorkshire Miners, made no claims to give his audience a soothing and comfortable speech. Instead, he delivered a stimulating, provocative and highly personal view of the Nation's ill-health. He considered that in our evil capitalist society the sole motivation of all is to make the maximum profit. Doctors are not exempt from this attitude. Indeed, Scargill claimed we would rather invest in a Starsky and Hutch poster corporation, raising 20% annual interest, than in new hospitals or cancer research, yielding 0% monetary gain. Perhaps he is right, though some of those present thought otherwise. Mr. Scargill had plenty to say on the subject of unemployment, which he saw as an important manifestation of our current economic ills. Official figures now quote 1.4 million out of work. However, the true number is over 2 million when one includes those involved in government job-creation schemes and those seeking work but not receiving unemployment benefits. We appear to be training young people for the dole queue and little else.

But why do we have, "The most cock-eyed and mixed up society possible"? "Mary Whitehouse and her boyfriend Lord Longford", consider it is because "Boy meets girl and goes to bed". Scargill succinctly dismissed this by saying, "She's got more chance than frying snowballs". The Common Market has much to answer for since its rigid bureaucracy has stifled trading agreements between Britain and non-E.E.C. countries. The high price of basic foodstuffs, such as butter, wheat and beef, within the Community as compared to world market values has further damaged our economy. Worst of all, vile and extremist organisations, in particular the National Front, are beginning to thrive in the midst of this chaos.

So how can we rectify our economic problems and make Britain a better place to live in? "Moses' " (Callaghan) idea of wage restraint as the panacea was given short shrift by Scargill. Surprisingly, Mr. Heath's policy of threshold agreement found more favour with our speaker. Indeed, Mr. Scargill was quick to affirm the truth in the *Daily Mail* headline, "Scargill says better off under the Tories". However, these are merely short-term objectives. What is required is a basic change in people's value and attitudes. We need to adopt a truly democratic electoral system, namely that of proportional representation. In the immediate future this would lead to the dissolution of the Lib-Lab pact and the demise of the Labour party but ultimately it would force the public to choose between a capitalist or a socialist ideology. Scargill also seeks the election of cabinet ministers by a whole party committee rather than at the whim of the Prime Minister. In addition, he wants to take over some of the white swans of industry, rather than being saddled with yet more lame ducks. He has his eyes sharply focused on the big four banks, who made £851 million in profit last year and also on some of the larger, more affluent building societies. Scargill's aim is an idealistic, non-mercenary world where people own and control the trades they are employed in. There, men would work together for mutual benefit and happiness. In his society there would be no wars and no unemployment and people would have much leisure time. A pleasant place indeed but scarcely a realistic one.

C. M. Haw.

Addition to the Summer programme:

Tuesday, 6th June 1978 at 5.00 p.m. in the Tower Lecture Theatre. Edward de Bono—Director of the Cognitive Research Trust in Cambridge and advocate of the concept of lateral thinking. Because his demonstration will require active audience participation, he has asked that all attending the meeting should bring along writing material.

The proposed debate of censorship has been postponed until next term —so please note that there will be no meeting on 20th June, 1978.

The 1977/78 academic year has perhaps proved to be the most ambitious within the history of the Quodlibet Society. The varied topics and speakers have succeeded in attracting an equally varied section of people who work and study at Guy's.

Next year is the Society's 21st anniversary and in accordance with the trend in celebrating such an achievement, we intend to provide some exceptional presentations.

DOWN HOUSE

The Home of the Darwins

By Sir Hedley Atkins

The excuse for writing about this house, owned by the Royal College of Surgeons, is that I was invited to do so by the Editor, also because for the last sixteen years my wife and I have been privileged to live here. It is not by any means a grand house; in fact, when Charles Darwin came to live here in 1842, it consisted of a cubical block rather like a slightly elongated lump of sugar, to which, during the course of the next forty years, he added two wings which made it more handsome to look at from the outside and far more commodious within.

In 1836 Darwin returned from his famous voyage round the world in the "Beagle", a voyage almost as significant for posterity as that of Christopher Columbus in regard to its effect on scientific thought for future generations. In 1839 after three years of bachelor life in London he decided to get married and the lady of his choice was his cousin Emma Wedgwood; so he had to look for a home suitable for a family.

Darwin had already experienced those symptoms of an illness which was to plague him for the rest of his life (some people, mostly doctors, decided that this was a neurosis; others, mostly laymen, thought that it was Chagas' Disease, due to a bite from the *Triatoma infestans* when in South America and the argument still rages). Whatever it was, he wanted to find somewhere in the country where he could live quietly, undisturbed by the social commitments of London and where he could write up the discoveries he made on his voyage round the world. First he and Emma explored Surrey, then they tried Kent and here eventually they found Down House. At first, Emma thought that it was horrible and so it probably appeared. It was plain, cold and unsheltered, being almost on the summit of the North Downs. *But,* it was quiet, half a mile from the village of Downe (then spelt "Down") and surrounded by fields and hills; and so it is today.

The house is situated more than a mile from the Bromley-Westerham road down a rather narrow lane and from the upper floors on the north-east

side there is a view extending to the far side of the Thames Valley twelve miles away, and to the south-west a vista of gently wooded slopes for about a mile. From the windows of the house, unless you peer round the corner so to speak, there is not a building to be seen nearer than three miles away.

On the first occasion that Charles and Emma visited the house it was cold and rainy and this may have discouraged Emma, but on their second visit it was warm and sunny and her apprehensions melted away. So it was that Charles, borrowing about £2,000 from his father, Dr. Robert Waring Darwin, which was the price of the freehold, moved in. Over the next forty years their family grew and eventually there were two daughters and five sons who, together with six maids, a butler and a cook also living in, required for their accommodation the additional wings to which I have referred.

Here it was then that Darwin wrote *The Origin of Species* sitting in his study on the ground floor with the manuscript on a board on his knee. Here he wrote all the other famous books, such as *The Descent of Man, The Expression of the Emotions in Man and Animals* and many others, books which have captured the imaginative attention of scientists the world over. This is a room which we keep exactly as it was in his day with almost all the original furniture, including the knee-board, donated by Charles' descendants. So too with the drawing-room looking out on to the garden and croquet lawn, a room which houses the original furniture and pictures together with the grand piano on which Emma used to play to Charles every evening after supper. The whole ground floor is given over to the museum: an exhibition room illustrating the theory of evolution in pictures, the old dining-room housing Charles' writings and some personal treasures. One room reserved for the relics of Erasmus Darwin, his famous grandfather, and then the garden—two acres of it (they had four gardeners!) and the famous Sandwalk around which Darwin, accompanied for many years by his dog "Polly" would walk between midday and one o'clock almost every day of his life.

It was in this house, almost certainly in what is now our sitting room, that Darwin died in 1882 propped up in bed and looking out on his beloved garden.

I'm sure you would enjoy making a visit, well under an hour from Guy's by car; or by train to Bromley, then by "bus" to Downe. The best time is in the summer months so as to enjoy the garden and the Sandwalk. Saturdays and Sundays can be rather full of visitors in the summer and Tuesdays, Wednesdays or Thursdays are best between 1 p.m. and 5.30 p.m. The public parts of the house and grounds are *closed* on Mondays and Fridays.

We get about 6,000 visitors a year so that this short article is not intended as an advertising brochure because the present number of visitors is about our limit and so we don't want many more, but Guy's visitors will always be welcome. The 50p (children 20p) admission fee goes to support the estate and improve the facilities.

With visitors from Guy's, provided I am not out, busy digging, weeding, mowing or driving round on a tractor, I should like to have a little chat and tell you some of the history of the estate and of the remarkable family which lived here.

Would you like to see the apparatus, designed by Darwin's son Francis, to show that earthworms were responsible for the topsoil of the countryside? Would you like to see the greenhouses where Darwin did all his experiments on orchids? Would you like to see the Old Study where this great biologist pondered and wrote works which have influenced philosophical thought throughout the world, or would you like to come with your family and sit in the garden where Charles and Emma sat a hundred years ago, basking in the sunshine and watching their children and grandchildren playing on the lawn?

Bring your own children who may run about freely, but not (if you would be so kind) your dogs. Otherwise they will get into trouble with my own labrador who is of the sweetest disposition in regard to members of the human race both young and old, but is irrevocably convinced that, as far as the canine population is concerned, the whole estate belongs to him, and so in a way it does. Darwin would have approved of this because his dogs, especially "Polly", thought that the grounds were created especially for their pleasure.

If you take a stroll round the Sandwalk, which Darwin called his "thinking path", this takes about ten minutes, unless you "jog" when even a septuagenarian can do it in four, you will come to a dividing of the path. It doesn't matter which way you take because this is where there is a loop so that you can walk down the sunny side and back by the side shaded by the trees which Darwin himself planted in the early 1840's, or the other way round. Alas! the elms have had to be felled, but there are plenty more trees: oak, beech, sycamore, holly and, in season woodland flowers for your delight. Where the path divides Darwin would pause to decide how many times he would go round. He would then take that number of flints and put them in a little heap on the ground. Each time he went round he would kick one away and, when they had all gone, it would remind him to go into lunch. Take a look at the broken surface of some of these flints as many are decorated by implanted echinoid fossils.

But how did the flints get there? Darwin thought that they were carried down embedded in the red clay topsoil during one of the ice ages and deposited on the fundamental chalk, but the ice never spread south of the Thames Valley. Other theories are now propounded.

There is so much to see and, like Darwin himself, to ponder over in this house and small estate of twenty-seven acres that I know you will enjoy the visit. Even if it's raining there is more than enough in the museum to keep you interested for an hour or, if a serious student of evolution, for a day.

You will be very welcome, so choose a fine day and come and see us!

A WEEK IN THE PHARMACEUTICAL INDUSTRY

by Rosalind Newton, Robert Heard, Michael Lind and Adam Snape

The profits made by the pharmaceutical industry are often the subject of hot debate in medical circles. The only contacts that doctors generally have with the industry are meetings with well-rehearsed representatives, the glossy and expensive advertisements in medical journals, and the annual calenders to hang on the wall. The impression gained is that the industry

LEAVING COLLEGE THIS YEAR?

Fill in an 'account transfer' form now.
We'll have your Barclays account waiting at any branch you choose on the date you choose.

The last thing you want when you graduate is all the fuss of transferring your bank account.

So, if you bank at Barclays, all you need do is fill in the form below and bring it with you next time you call at your branch.

This will ensure that when you leave college your account will be transferred to whichever Barclays branch you choose.

Finally, if you have any problems about your finances, or are not sure of the location of the nearest Barclays to your new address, don't forget your Student Business Officer will be happy to help.

To BARCLAYS BANK LIMITED

Present Branch Address: _____

Please transfer my/our account(s) on (date) together with any securities, boxes and parcels, authorities and bankers orders which you hold on my/our behalf to:

New Branch Address: _____

*Please advise Barclaycard of my new address. My card number is: _____

My New Address: Signature(s)

_____ _____

_____

_____ _____

*Delete if not applicable

NOTE:
Any unused cheques drawn on the branch from which the account is transferred should be returned, preferably in person, to the office on which they are drawn or to the new account-holding branch. Unused personalised credit slips should be destroyed and a fresh supply obtained from the new branch.

Published by Barclays Bank Limited, Reg. No. 48839. Reg. Office 54 Lombard Street, London E.C.3.

must be making exhorbitant profits; indeed if doctors had to charge their patients for all drugs used in their care, then criticism of the industry would certainly increase.

If this impression does exist then it is the result of too little knowledge of the industry and the risks that it takes in developing new drugs. The pharmaceutical industry naturally would rather that there was greater awareness of the various sides to drug development, but the means by which it can achieve this are limited. One way is to give complete and informed access to their establishments to users of their products and especially to medical students. This Pfizer did for the first time by inviting the four clinical pharmacology B.Sc. students to their plant at Sandwich, Kent for a week.

Coming from a medical school environment we were immediately struck by the scale of operations and it soon became clear that drug development was a very complex process. We were introduced to all of the many stages of drug development including initial isolation of substances, biological screening for activity, toxicity testing, metabolism, small scale production, volunteer studies including pharmacokinetics, large scale production, clinical trials, submission to the Committee on the Safety of Medicines, marketing, promotion and post-marketing surveillance. The time span from start to finish of this process can be a considerable number of years, and a potential drug may have to be discarded because of problems at any one of these stages.

Thus a drug company may invest a great deal of money, manpower and resources in developing a drug only to find that they cannot submit it to the C.S.M. For instance, a few years back Pfizer were investigating a new cardioselective beta-blocker Tolamolol, which had appeared extremely promising at every stage, including clinical trials, but which had to be abandoned shortly before the drug was due to be launched as the result of a small amount of evidence indicating that in very high doses the drug was carcinogenic in animals.

One major problem in developing a drug is scaling up the synthetic process to a manufacturing scale. Very often the most convenient method of synthesizing a drug in the laboratory is not suitable for large scale production while economics may also be a problem. In addition there are particular difficulties in producing sterile dosage forms, and in ensuring quality at every stage.

A candidate drug must satisfy the requirements of the C.S.M. in the U.K. and the Food and Drug Administration in the U.S.A. These legal requirements are very stringent, indeed there is a feeling within the industry that they are so strict as to hinder the development of new drugs. Most drug companies in this country are members of the Association of British Pharmaceutical Industries which exists to maintain these standards.

Obviously the process of drug development generates a vast quantity of data and literature which must be assimilated and be easily accessible so that besides a vast range of journals in the library there were microfilm storage and retrieval facilities, and the particularly impressive computer facilities for locating references. Access could immediately be gained via Medline to the Index Medicus and also to the larger classifications in California.

So the process of drug development is both costly and time-consuming with the companies bearing considerable responsibility because virtually all the development and production of new drugs is carried out by the industry—a situation could be regarded by some as giving the companies considerable monopoly but it is difficult to see how it could be changed in the future.

It really took us a week to be able to see the process of drug development as the completely integrated and complicated process that it undoubtedly is, and we are very grateful to Pfizer for giving us the opportunity to do so.

11-19 ST. THOMAS STREET— OPPOSITE CONYBEARE HOUSE

by A. H. Burfoot, Clerk to the Special Trustees.

These houses near the Chapter House on the north side of St. Thomas Street were built for the Receiver, the Minister and the Apothecary of St. Thomas' Hospital in the mid 18th century, and where 19 St. Thomas Street now stands were the Treasurer's stable and his stable yard.

When the new railway to Charing Cross forced St. Thomas' to move to its present position opposite the Houses of Parliament, 11-19 became the property of the South Eastern Railway Company. They were bought by Guy's in 1897 and re-sold by Guy's to the South Eastern Railway in 1900. I suspect, but cannot be sure, that the purchase was an investment while the sale was forced by the need to raise cash to reduce a large Bank overdraft 3 years later.

When I came as a trainee to Guy's in 1946 one of my first tasks was to prepare the legal division of the overall Guy's site between the new Board of Governors, the Medical School and the Endowment Fund. Among the many Deeds and papers which dated back for more than 200 years I found a copy of the Conveyance from Guy's of these houses in 1900 which provided that should the Railway ever wish to dispose of the houses Guy's should have first option to re-purchase for £13,672 1s. 6d.

In 1967 British Rail found they no longer needed the premises and they were reminded of the option which Guy's had. As they could have leased to a third party rather than sell to Guy's the Endowment Fund had in the end to buy at rather more than the stipulated sum, which from British Rail's point of view was understandable enough. By this time the buildings were in a very dilapidated condition and it was clear that in a comparatively short space of time considerable work would have to be undertaken if they were to remain standing. Their Town Planning use was for office purposes and for a few years they were used by the Hospital in this way with temporary permission for the Chaplain to live at No. 11. By 1976 the buildings were so unsafe that the Special Trustees decided to carry out a major scheme of reconstruction to put them into a structurally sound condition while preserving their 18th century character, and refurbish them for their planned use as offices. This scheme should be completed in the Autumn of this year and it is likely that they will then be reoccupied by the Hospital for its own office use.

ON BUILDING A PRIVATE HOSPITAL NEAR GUY'S

By Mr. T. L. T. Lewis

"46 Chamberlain's Wharf, Tooley Street.

Change of use from warehouse to a private hospital, together with external alterations including the formation of a ground floor car park, the erection of balconies, and the landscaping of the existing jetty."

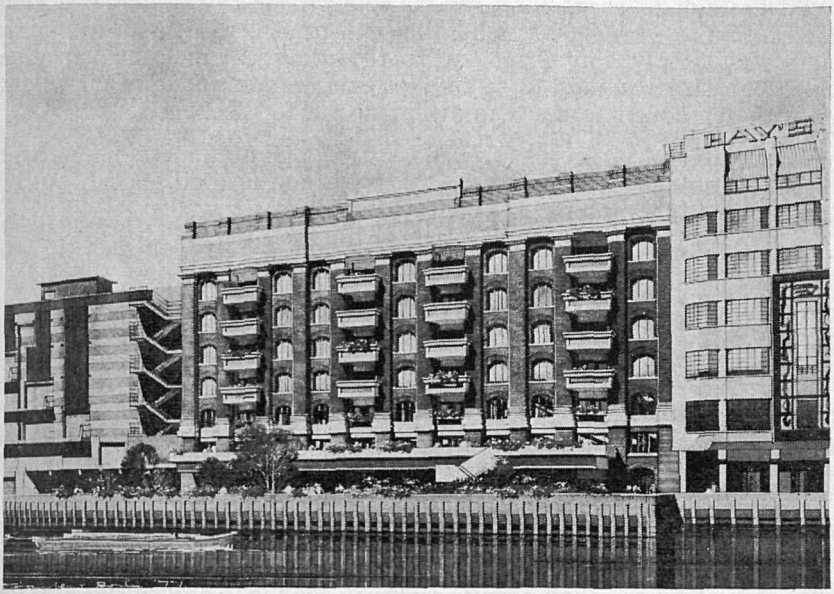
Thus read the heading of a planning application which was considered at a meeting of the Planning and Development (Applications) Sub-committee of the London Borough of Southwark on 25th April, 1978. The Chairman of the Sub-committee said he was concerned only with the planning aspect; that he had received a number of objections and that Chamberlain's Wharf, forming part of the Phase 2 development of Hays Wharf, should not be prejudiced by an approval to a building on part of the site. The application was therefore rejected.

Nuffield House, containing 78 beds, was build in 1936 in the grounds of Guy's by Lord Nuffield out of his own pocket for the admission of patients "of moderate means" to be treated privately by Guy's consultants. In 1948 when the National Health Service was established by Mr. Aneurin Bevan it was agreed with the profession that there would be a small number of beds for private use within the Health Service. Nuffield House was taken over with the rest of Guy's by the State and remained as a private block until the Health Services Act was passed by Parliament in 1976. Following union pressure the Secretary of State, Mrs. Barbara Castle, obtained the agreement of Parliament through the Act to phase out private beds from the N.H.S. and the Health Services Board was set up under the Chairmanship of Lord Wigoder to see to this. At that time there were 467,308 beds in the N.H.S., 4,191 of which were private (less than one per cent). The Health Services Board was instructed to phase out 1,000 private beds immediately, the rest to follow later. The private beds in Guy's were reduced from 97 to 64, 55 of which were in Nuffield House. The private beds still in use in the N.H.S. may continue only on condition that there is sufficient demand for them by private patients, that there is no alternative accommodation available in the area and that *reasonable steps have been taken to provide such alternative accommodation.* Thus, for doctrinaire reasons, the Government has deprived the public of the right to private accommodation within the N.H.S. and the N.H.S. of a significant income. They have done away with a most satisfactory compromise solution to the problem of how a consultant may do a little private work without any disadvantage to the N.H.S.

Previous to 1976 Dr. Joiner had been exploring the possibility of rebuilding Nuffield House on its present site or on sites in the neighbourhood of Guy's but for various reasons, including refusal by the London Borough of Southwark to grant outline planning permission to build in Southwark Street, these projects fell through.

Faced with the prospect of losing the beds in Nuffield House the consultants at Guy's, whole-time and part-time, who were interested in private practice met for the first time in December 1976 and twice in 1977. They determined to explore the possibility of building a private hospital in place of Nuffield House on a site near Guy's if one could be found; and to keep the private beds open in Nuffield House as long as possible while alternative

accommodation was being made available. A small working party consisting of Dr. N. Simmons, Dr. J. Liddell, Mr. F. Ellis and myself was elected to act on behalf of all consultants and to report back.



Artist's impression of the proposed hospital.

Firstly it became necessary to have prepared a legal document setting out all the previous attempts which had been made "to provide alternative accommodation" for the Health Services Board in order that the 64 private beds in Nuffield House should be permitted to remain in use. Secondly the help of experts in the field of hospital building had to be obtained. The working party interviewed a number of firms and eventually selected Process and Energy Consultants Limited and Hospital Design Partnership (well known for the Best Buy Hospital and other projects) to advise them. A sum of money was collected from each consultant to pay for the legal and professional services of those firms and a series of meetings was held by the working party throughout the Summer and Autumn of 1977. By the end of the year we had the option to buy Chamberlain's Wharf, a magnificent site on the riverfront with views across the river to St. Paul's Cathedral, the City and the Tower of London. It is part of the Hays Wharf complex, next door to their main office block. By skilful planning the architect, Mr. James, had designed a hospital with 95 beds within the walls of the warehouse without changing the skyline. The ground floor was for movement of traffic under the building and for parking of cars. There was a garden for the use of the public between the building itself and the river. All disciplines, medical and surgical and ancillary, were included in the plans together with consulting rooms, within one hundred yards or so of the front entrance to Guy's. The cost of the hospital has been estimated at about £5 million

and although we do not have the money we have good reason to believe it will be forthcoming. From our calculations the daily cost of a bed in the hospital will be well within the range covered by the medical insurance companies. The aim is therefore to provide a hospital for local, regional and British (as opposed to foreign) patients and to build it with British money. It could be built in about three years. Being so near to Guy's consultants would be able to combine their hospital and private work with a minimum of time wasted travelling from one to the other. Whole-time consultants would be able to continue to rely on private fees to add to their research funds with consequent benefits to medicine and to the N.H.S.

Now that the project has been refused planning permission by the Southwark Borough Council we are having to consider an appeal, but even if that succeeds the scheme is bound to be much delayed.

OCCUPATIONAL MEDICINE

Philip Razzell recently interviewed Dr. Suzette Gauvain of the Employment Medical Advisory Service, lately Deputy Director of Medical Services, Health and Safety Executive, and at present Consultant Adviser in Medical Training.

Gazette: Dr. Gauvain how did you become involved in occupational medicine?

Dr. Gauvain: Like so many people, really by chance. I was working in long-term orthopaedics and had to obtain leave from my job when my husband and I moved to the Lebanon for a period. We returned and on the advice of the Post-Graduate Medical Federation I went to see Dr. Donald Hunter at the London Hospital and he suggested that I go on the Diploma in Public Health course at the London School of Hygiene and Tropical Medicine. On that course there was an opportunity to study occupational health, which I enjoyed. I did my Diploma in Industrial Health and subsequently joined the staff of the T.U.C. Centenary Institute of Occupational Health at the London School of Hygiene and Tropical Medicine.

Gazette: It has been said that people in occupational medicine consist largely of discontented G.P.'s and toxicologists. Is there some truth in this?

Dr. Gauvain: It's a little unfair! Firstly, we are desperately short of toxicologists—I wish we had a lot more! We have a lot of part-time G.P.'s—about two or three thousand with part-time posts in occupational medicine in this country and there are between five and six hundred full time occupational physicians working in industry.

Gazette: Is it true that occupational medicine is not within the N.H.S?

Dr. Gauvain: Absolutely. Occupational medicine is quite separate from the N.H.S. For many years there has been a great deal of discussion as to where occupational medicine should go, and many thought it should be within the N.H.S. The option can be used at any time because it is part of the Employment Medical Advisory Service Act 1972 that it can become part of the D.H.S.S. if this should be desired in the future. There is no

occupational health service nationally, but we are a national occupational medical advisory service, as part of the Health and Safety Executive, which was set up as a result of the Health and Safety at Work Act 1974. Occupational health services are only in those industries who either pay for it themselves or who belong to a group occupational health service, of which there are several well established in different parts of the country, such as at Slough, the Central Middlesex, Harlow, the West Midlands and so on.

Gazette: What are the range of jobs available in occupational medicine?

Dr. Gauvain: Jobs vary tremendously in the type of work and grading, the Employment Medical Advisory Service and the nationalised industries are major employers—for example the National Coal Board, the Electricity Generating Board, British Steel and British Airways. They have quite large services with doctors and occupational health nurses and often occupational hygienists. There are many smaller industries who have their own doctors and nurses, though the number employed in an industry relates far more to its size than to its hazards.

Gazette: Do many doctors come into occupational medicine by chance?

Dr. Gauvain: An enormous number, but I think this is likely to change in the near future. Often it has been a second career choice for people who have been in the armed forces medical services or who have been in general practice, or in some other branch of medicine which has led them to become interested in the effects of work on health.

Gazette: How does one get into occupational medicine?

Dr. Gauvain: At the moment often by chance, as I have said. Posts are advertised in the medical press and by the Job Placement Service of the Society of Occupational Medicine. However, I think that if a newly qualified doctor wants to go into occupational medicine he or she should enquire about the possibilities and think hard first. This is a clinical specialty and doctors should be well qualified clinically before entering what is really a post-graduate branch of medicine. Occupational medicine is such a mixture of clinical specialist skills that I can see openings for psychiatrists, pathologists and surgeons and many other specialists in addition to physicians. It is quite obvious that the haphazard and chance way that so many people have gone into occupational medicine indicates that it is now necessary to have a clearly defined "way in". The Joint Committee on Higher Medical Training of the Royal College of Physicians has accepted occupational medicine as a specialty and it has defined a course of general professional training. This is primarily a training in general medicine ending either with the M.R.C.P. or an equivalent qualification acceptable to the Specialist Advisory Committee (S.A.C.) in occupational medicine. The Doctor would then be eligible for higher specialist training of four years duration, consisting of rotating appointments approved by the S.A.C. and sometime at least will be spent in a university department of occupational health. It is expected that there will be career openings in research, academic medicine, in the specialist clinical departments of the N.H.S., in the Employment Medical Advisory Service and of course in industry.

Gazette: Is training available now?

Dr. Gauvain: Yes, but only from some companies and a limited number of university departments; viz. London, Manchester, Newcastle and Dundee. In London they run both a full time course for the Diploma in Industrial Health, and a part-time day-release course over eighteen months, and a full and part-time M.Sc. course in occupational medicine and occupational hygiene; which is of one or two academic years and which requires a research project. The Society of Occupational Medicine and some university departments provide short courses of training but there are very few basic courses available for the part-time G.P. This is a tremendous need.

Gazette: Can you tell me about the functions of the Employment Medical Advisory Service?

Dr. Gauvain: This is the successor to the old Medical Inspectorate of Factories and came into operation in February 1973. After the Health and Safety at Work Act of 1974 it became part of the Health and Safety Executive. Its function is to give advice on all medical aspects of employment, to the Inspectorates of the Health and Safety Executive, the Health and Safety Commision, the Department of Employment, and particularly to unions and employers. Its main objective is to aid in the prevention of health hazards of work and I would emphasize the importance of clinical studies and epidemiological surveys in this respect. Secondly it advises on the biological monitoring required for workers who may be at risk, complements the monitoring of the environment required to minimise health hazards related to employment, and monitors the effect of action which has be taken to reduce these risks. The Employment Medical Advisory Service advises and informs both workers and employers of any known or suspected hazards to health of which they are aware and to which exposure may occur and also advises on the employment of disabled people and on rehabilitation for employment.

Gazette: Do you see any overlap between a doctor employed in a factory and G.P.s caring for the work force outside the factory?

Dr. Gauvain: I think there is a very important ethical problem here. The workers and their families are patients of their general practitioner and when they are at work they are still his patients. However, any ill effect of work on health or health on work is obviously of great concern to the occupational physician, but the ethical relationship is crucial. The doctor in industry undertakes emergency treatment and with the permission of the G.P., may undertake some treatment at work. This may be very desirable, for instance when the workplace is some distance from N.H.S. facilities. I don't think enough work has been done on how best treatment and diagnostic services, such as X-ray examinations of workers, should be divided between the occupational health and national health services. The N.H.S. sometimes has difficulty in coping with the problems created by industry. It is up to the occupational physician to inform the G.P. of everything he does, and it is the G.P. who normally refers the patient for any consultant advice, unless he informs the occupational physician that he may do so.

Gazette: Do you consider that the doctor has a neutral role in industry? On the one hand he has the health care of workers and on the other he helps to maintain the productivity of the company. Can there be a conflict of interests here?

Dr. Gauvain: I am sure that one of his aims would be to see that the company does well, but his primary aim is to prevent illness in the workers and to advise management of the need to maintain for them a safe and healthy working environment. Though the doctor is in practically every case employed by the management and not by the workers, most doctors are extremely anxious to be completely neutral and to give the best medical advice to workers and management—though there are undoubtedly occasions when difficulty can arise. The doubt about a doctor's role started I think when the Workman's Compensation Act came in. Then management employed doctors not to protect the health of the workers but to protect industry from compensation. Everybody in occupational medicine would like to assure workers that they are neutral and really convince them of this.

Gazette: What part do you see workers playing in the maintenance of their own health?

Dr. Gauvain: A large part. Here I think health education from doctors, nurses, management and unions contribute. As one example, The Health and Safety Executive produce and distribute leaflets on skin cancer caused by industrial oils. The purpose of this leaflet is to make workers aware of this problem and to encourage self examination.

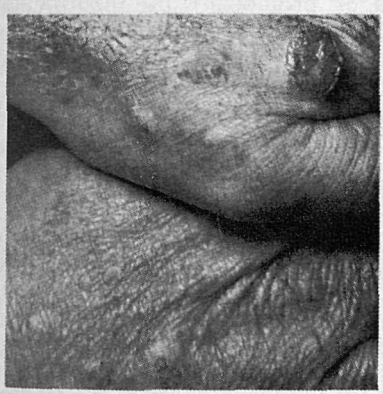
The problem with screening programmes alone is that they are in no way preventative—they merely assess health at a particular time. Therefore

The first stage of a cancer from oil is a rough patch of skin or a wart. These may develop on any area of the skin where there has been continuous contact with oil, and may become true cancers unless treated.

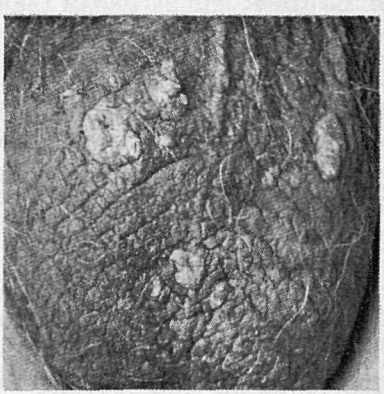
Do not wait until the rough patch or wart is as big as illustrated here before going to the doctor.

A wart on the SCROTUM requires
IMMEDIATE MEDICAL ATTENTION

Take this leaflet with you to your doctor.



Early stage of cancer of the skin of the hands



Early stage of cancer of the skin of the SCROTUM (This is NOT V.D.)

Part of a Health and Safety Executive pamphlet warning workers of the danger of exposure to industrial mineral oils.

individuals can contribute to the maintenance of their own health by seeking advice on any symptoms of ill health early and taking note of the health education advice they are given. Health education is a very important part of an occupational health service.

Gazette: And general safety at work presumably?

Dr. Gauvain: General safety at work is a primary responsibility of management. Workers have a responsibility to take due care and to obey safety instructions. The Inspectorate of the Health and Safety Executive and the Factory Inspectorate, advise on and can enforce compliance with safety legislation. More and more of the unions will be concerned with safety through their own safety representatives and through safety committees. Safety Representatives legislation comes into force in October 1978. This will have a great influence and will heighten the need for training in occupational health and safety.

Gazette: How far is occupational medicine nationally co-ordinated?

Dr. Gauvain: It will be much more co-ordinated with the new Faculty of Occupational Medicine at the Royal College of Physicians when this comes into being later this year. There will then be professional representation influencing the training and status of occupational physicians, although it will not necessarily influence the organisation within each industry. There is no national plan as in the N.H.S., though there is, as I have said, a plan for a specialist career structure.

Gazette: Do the government lay down minimum requirements for the number of doctors working in industry?

Dr. Gauvain: No. The requirements are for a healthy and safe working environment, and this is enforced by the Factory Inspectorate. There are no requirements for occupational physicians or occupational health nurses. There is legislation for first aid, which is at present being considered for revision by a specialist sub-committee of the Medical Advisory Committee of the H.S.C.

Gazette: What are the areas of current need in industrial toxicology?

Dr. Gauvain: I think one of the most difficult problems is the identification of occupational carcinogens and more and more work is being done on research into the identification of such substances. While this requires knowledge of the toxicity of chemicals, it is not necessarily a medical expertise. Many industries have their own research laboratories, as does the Health and Safety Executive, who are also major sponsors of research.

Gazette: Should the occupational physician regard himself as part of a team?

Dr. Gauvain: Very much so. The doctor in occupational medicine is part of the health and safety team consisting of nurses, occupational hygienists and other safety professionals such as safety engineers, safety advisers, safety officers and, of course, first aiders. Teamwork is vital because occupational health combines two major disciplines, firstly occupational medicine and occupational health nursing; concerned with man and the influence of work on health, and secondly occupational hygiene and safety; concerned primarily with the inspection and control of the working environment. These are complimentary. In short, all have a part to play in recognising, assessing and controlling hazards to health. The Health and Safety Executive emphasises the team approach. The Employment and Medical Advisory

Service has approximately 108 doctors and 25 occupational health trained nurses and 60 nurses working in Employment Rehabilitation and Skill-centres, who are all part of the occupational health and safety team.

Gazette: Thank you very much Dr. Gauvain.

Sources of Information

E.M.A.S. The Employment Medical Advisory Service, Health and Safety Executive, Baynards House, Chepstow Place, London, W2 4TF.

An Introduction to the Employment Medical Advisory Service—obtainable from the same address.

The Hon. Secretary, The Society of Occupational Medicine at the Royal College of Physicians, 11 St. Andrew's Place, Regents Park, London, N.W.1.

Occupational Health Services: The Way Ahead, Health and Safety Commission. H.M.S.O. 50p.

I BREW—THEREFORE I FART

by Dr. Ken Gillman

Many afficionados of real ale might consider the editor was enjoying an afflatus when he suggested an article on brewing. Students of semantics may also note a descriptive inaccuracy in the title, since the alimentary consequences of the consumption of real ale intrude, in an enduring way, primarily on the nasal organ. Indeed it is held by some (and released by others) that this property correlates more significantly than any other single measure with the qualities of the ale. To discover the factors that control these delightful properties of ale we must explore the mysteries of sparging, the delights of the decoction mash, and discover what to do with the wort, and what a fuggle is, and whether Mary Whitehouse would be upset if she found you using Irish moss to achieve a hot break.

The misnomer of "real ale"

To call the beer that is brewed nowadays ale is really a misnomer since ale is the product solely of pale malt which is the basic ingredient of modern beer but the sole ingredient of old-fashioned ale. The first stage in the evolution of modern beer from the ancient ale came with the addition of hops which were probably added for their preservative qualities rather than their flavour. Subsequently many other adjuncts came into use to alter the properties of beer and led to the evolution of the various types of beer that we now drink. It is the relative proportion of these adjuncts and the different hopping rates which determine the type of beer produced. What is now called Pale Ale is the nearest to the old-fashioned ale since it is made purely from crushed malt with no other additives, and has a much higher hopping rate than mild or bitter. Bitter derives its characteristic flavour mainly from crystal malt, and heavier beers like stout from roasted barley which gives them their characteristic dark colour.

The differences in body and strength that exist between the various types of beer are mainly a matter of tradition and it is perfectly possible to brew a heavy and alcoholically strong pale ale. The weight and the alcoholic strength of the beer is governed by the starting gravity which is the specific gravity of the unfermented wort, and this in turn is governed by the weight per gallon of pale malt and adjuncts. Hence, assuming the beers are fully fermented out, a beer with a starting gravity of 1050 will be

alcoholically stronger than a beer with a starting gravity of 1040. This only applies providing the strength is not artificially made up by adding sugar in the secondary fermentation. It is possible of course to make even a thin beer alcoholically very strong by this artificial means.

Now we must progress on to discover how mashing produces the fermentable products which ferment inside the barrel and some of which ferment inside you.

There was an old lady of Ryde
Who ate some green apples and died
The cider fermented inside the lamented
And made cider inside her inside.

Mashing

Mashing is the most culinary part of the process which involves mixing the pale malt with hot water to achieve a thick porridge-like mash. The mash must be kept at a critical constant temperature of 150°F. This indeed is the heart or guts of the problem. During mashing the starch in the grains is converted to dextrin and maltose by the action of alpha and beta amylase. It is the long chain dextrin sugars which give rise to the keeping properties of the beer, both in bottle and in gut, and it is the beta amylase which produces the short chain easily fermentable sugars. The relative proportion of these sugars is critical and since alpha and beta amylase have different optimum pHs and temperatures the pH and temperature define the critical balance between the ratio of dextrin and maltose. Hence we reach the conclusion that alpha amylase activity and flatulence are significantly and positively correlated. The ideal ratio of maltose to dextrin is 75: 25 and it is the 75% short chain maltose sugars that produce the rapid primary fermentation which is followed by the much slower secondary fermentation which represents the break down of the longer chain dextrin sugars. From this it is easy to understand why the beer is racked and bottled after the primary fermentation when all the maltoses have been fermented out leaving only the much slower fermenting dextrins which produce the condition (gas) which pressurises a live beer. This point at which the beer is racked is therefore known as the quarter gravity stage since it is the point at which three-quarters of the fermentable portion is spent. A beer of starting gravity 1040 would therefore be racked at about 1010. The alcoholic strength of the beer can be calculated from the difference in starting and racking gravities by dividing by 7.46.

The above example which would be typical of a good commercial beer would come out approximately 4% alcohol by volume.

Sparging, hopping and boiling for a hot break

And on to sparging which is the process by which a sugary malt is extracted from the mash, thereby producing the wort. The whole operation could be compared to a sewage filter bed in reverse, where the whole point is to wash out the goodness from the mash by letting it settle to form its own filter and sprinkling hot water over the top and allowing it to percolate through carrying the wort with it. This constitutes a mysterious process called sparging. So, having sparged your mash to get your wort, what next? That thick, sticky, dark, amber fluid called wort is the *raison d'être* of the brewer. It is the wort with which the brewer will work his craft. It is also the stage at which spillage will cause the greatest disaster as anyone who has tried to clean wort off a kitchen floor will testify. This experience can be easily enjoyed by omitting to turn off the tap in the wort container before pouring in the wort. This is where the noble hop makes its appearance, although sadly in rather small quantities in modern commercial beers,

the hopping rates of which have dropped in a manner inversely proportional to their price. Indeed the best thing about home brewing is that you can put the hops back into beer. Perhaps if people realised how closely related the hop plant is to the cannabis plant they would do this more enthusiastically. The various hops which are commonly used in English beer carry magnificent names like Fuggles, Bramlings, Bullion and East Kent Goldings. Your chosen mixture of these are boiled vigorously with the wort to marry the flavours and impart the aroma and keeping properties of the hops to the wort. It is worth doing this just for the smell. Boiling the wort continues until you achieve a hot break. This is nothing to do with any alternative actitives you may be engaging in whilst the wort is boiling. It is the technical term for the point at which the protein matter in solution floculates and precipitates out. If you enjoyed your hot break you will be delighted to know that further pleasures are to come when you achieve the cold break (this, it should be noted, bears no relationship to the activities of Eskimo Nell, but relates more to the physico-chemical properties of coloidal solutions which dictate that a further quantity of protein precipitates out on cooling). The wort being spent as it were can now be put to rest by being drained off from the protein precipitate into a fermenting vat. This is where the all important fungus makes its contribution and in no time at all the primary fermentation is bubbling with volcanic fury until, at the aforementioned quarter gravity stage, the rapid and vigorous primary fermention abates. The beer is racked off to a secondary fermenting vessel where the more sedate, prolonged secondary fermentation takes place. If a live beer with natural conditioning is required this operation is conducted in a pressure vessel so that when the beer is settled and clear it is dispensed under its own natural CO_2 pressure. Alternatively the beer can be bottled and left to attain condition in the bottle. This has the unfortunate disadvantage that sometimes the beer attains too much condition. When this happens digging the splinters of glass out of the wall can be rather tedious.

The final conclusion

And now we reach the best stage of all—the drinking stage. This stage, with home made beer, may often be surprisingly brief and lead to the horizontal stage which has been known to last a considerable time. This leaves but one delight providing you bath alone, that is counting the bubbles.

ETHICS AND COMPUTERS

by Dr. John Dawson, Secretary of the B.M.A.'s Central Ethical Committee

The advance of computers is inevitable—does the only safety lie in taking to the hills? Can the medical profession protect its patients? Doctors will be major users of computers within one decade and the British Medical Association's Central Ethical Committee is fighting to make sure that automatic data processing and clinical information can coexist for the patients' benefit.

The main dangers of jerry-building computer systems and the mindless use of the resulting machines are that information which patients want to be confidential may be carelessly or maliciously distributed to unauthorised busy bodies. In the past computer systems have been used to their maximum

capability to recoup very high capital costs and running expenses. This philosophy will apply to the type of computer used by many Area Health Authorities and generates the approach of "Have system—Need Uses".

Information stored on computers will inevitably be used for an increasing number of projects. The original reasons for collecting the information can be forgotten and new applications could well be to the detriment of patients. Medical records might be linked to employment office outlets to fit groups or individuals to "suitable" job vacancies. A similar manual scheme already operates for handicapped school leavers and is causing us some concern.

That's part of the bad news and at the moment it is these quasi-totalitarian developments that are of greatest concern. But in the murk and strife it is essential to hang on to a vision of how automatic data processing can help doctors and patients.

We know what we are fighting for: there are great benefits to be had from the adequately controlled use of computers in clinical medicine. The immediate future will probably bring further drops in the cost of small computers with, paradoxically, an increase in the computing power and speed of operation of these micro-systems.

Good News

When computers are available at much the same price as colour televisions the benefits of data processing will become available to patients in a way that is hard to envisage at present. We have been talking with a hardware and systems company for nearly two years and looking at the uses for a modified word processor in the G.P.'s surgery. Programmes can be written with the capability to handle the clinical records for a G.P.'s list of patients, his practice accounts and repeat prescription programme, while at the same time the risks associated with automatic data handling are minimised by the control exercised over his *own* machine by the G.P. He can pull the plug out when he goes home.

A programme on a word processor or similar system could allow the G.P. to maintain his standards of repeat prescribing, a necessary evil, at a consistently high level. Prescriptions for various classes of drugs would be allowable only if the patient had been seen within a defined time, for example he could impose a two week limit on night time hypnotics, or possibly six months' medication for a stable hypertensive. Drug interactions could be checked by the machine to a degree impossible to an overworked doctor. Think of good practice and the advantages trip over themselves.

Record storage, prescription production, and drug interaction information is already available, working as a pilot scheme on a huge computer system at Exeter. Visual Display Units in G.P.'s surgeries, out-patients' departments and hospital wards are linked to a very large mainframe machine in the grounds of the Royal Devon and Exeter Hospital. Although the machine is not under the physical control of individual doctors the information which the G.P.s and others have entered into the system is theirs to command in the interests of their patients. A complex, but simple to operate, passcode allows the author of ingoing information to enable fragments of varying size to be released to other partners of his practice, or

booking clerks at out-patients or to district nurses. The G.P. or other clinical author obviously has access to all his own records although he needs to key his passcode twice to read the most sensitive information. Size alone need not be a cause for concern.

Concern

The present proposals from DHSS for a system of automatic data handling for clinical records of all pre-school children from conception onwards are inherently weak. A batch processing system is envisaged in which a "run" is done on an AHA computer and hard copy, paper output is produced, carrying on it all the relevant clinical information about the baby or child, with space for the health visitor or clinic doctor to answer questions before returning the form to some central point for recoding and re-input to the computer.

The operation of the computer and the criteria for selecting which patients' records are to be produced in any output exercise will be under the control of an administrator whose primary responsibility must inevitably be to a superior administrator and not to the patients whose records he controls.

In some respects the situation would be similar to that of the hospital records department and there is presently cause for concern about confidentiality here as well.

The BMA has already given evidence to the Data Protection Committee and we await its report. Events are overtaking the DPC, however, and we have developed proposals which will be debated at the BMA Annual Representative Meeting in July. We believe the principles set out below will guarantee the interests of patients and their doctors adequately.

The Good Guys' Principles

Access to identifiable information held in medical records will be restricted to the author and the person clinically responsible for the patient during the episode for which the data was collected (or their successors) unless specifically authorised by the clinician in the clinical interests of the patient.

An individual shall not be identifiable from data supplied for statistical or research purposes except when follow-up of the individual patient is a necessary part of the research and the patient has given informed prior consent.

No doctor should be party to the recording or holding of clinical information on any computer system which cannot completely safeguard the confidentiality of such information.

Editor's Note:—

In a recent experiment to test the efficiency of an English/Chinese speaking computer the English phrase "Out of sight out of mind" *was fed in. The electronic wizard instantly returned with the Chinese equivalent for* "Blind idiot" !

THE ORAL HYGIENE CENTRE

A new concept in primary preventive dental care.

Prevention should have priority—so quoted *The Times* newspaper when it produced a supplement on dental hygiene in May, 1977, discussing the concept and advantages of the teaching methods and treatment available to patients to help them minimise tooth decay and gum disease.

Periodontal disease is a disease of neglect, and of all man's chronic health problems it is one that is to a very large extent preventable. The cost to the nation of treating dental disease is over £200 million a year and the pain caused to individuals and the lost time from work which is probably more than 10 million working days is a heavy price to pay for neglect.

This situation confronted Guy's dental surgeon, Dr. Neil Lawson Baker, and Dr. Tony Newbury from Melbourne, Australia, when they had an informal meeting in February, 1977, which led to the concept of a centre specialising in primary preventive dental care for central London. These two dental surgeons felt that they had a moral responsibility and a duty to the public to do something more than just talk about it. For too long they felt the profession had paid lip service to prevention, and they decided to have the courage to turn their ideal into reality, realising only too well the enormous task that lay ahead both in planning and investment.

Local and general researching soon made it evident that their idea was perhaps unique and although both individuals were totally involved in their own practices, it was decided to go ahead. A site was found near to the London Clinic, and the concept was already in first gear. Detailed planning and the whole rigmarole of permission from landlords, local councils, health authorities and a host of bureaucratic departments had to be negotiated while the embryo was establishing itself. Very soon came floor plans, designs, colour schemes, equipment, costing and a host of exhausting enquiries which upon reflection one wonders quite how all were coped with during a busy year of full-time practice. Finance was obtained with personal guarantees and at this stage it was realised even more acutely the enormity of the task ahead and the importance of making the result totally acceptable to the profession as a whole.

The whole scheme was laid out in a brochure for dental and medical colleagues and at every stage professional ethics have been the first consideration. It was stressed that patients would come to the Centre by referral unless they had no dental surgeon of their own and that under no circumstances would conservative dentistry be available—not even in an emergency. At this stage it was decided to approach one particular member of the dental profession who had special knowledge about dental hygiene and had played an international role in dentistry for many years as well as having practised for over 40 years in a house opposite the site for the proposed centre. This dental surgeon, Dr. Gerald Leatherman, Executive Director Emeritus of the Federation Dentaire Internationale and recipient of many honours from countries all over the world, assisted in founding The British Society of Periodontology and The British Dental Hygienists Association,

and is Honorary President of the latter. He also, whilst serving in the dental branch of the Royal Air Force during the last war, helped to establish the original training and deployment of dental hygienists whose work is now so valuable in the delivery of preventive dental services. He was therefore asked to join the team in a consultative capacity.

At this stage the General Dental Council and the Medical Protection Society Ltd. were approached to give them outlines of the whole scheme so that there would be no misunderstanding about the clinic taking patients away from other dental surgeons. In fact very much the opposite has happened and patients may present with friends who have no dentist and the Dental Directors can then find them a dentist of their own in the area where they live. Regretfully figures show that only 40% of the British public attend a dental surgeon regularly.

After exactly one year the outcome of all this work and planning is a very exciting new development in primary dental care known as the Oral Hygiene Centre, which could give a tremendous lead for the future and provide a blue print for preventive dental centres throughout Great Britain and Europe and indeed world wide.

The Oral Hygiene Centre opened its doors for patients in mid-January, 1978. It has provision for 8 dental hygienists under the constant supervision of one or more supervising dental surgeons. The operating areas are semi-open plan and there are 6 surgeries in all, 2 of which are in a separate room which is being developed for the treatment of children and where dental hygiene techniques will be taught in group sessions. Each operating area is self contained and used by an individual hygienist. There is a modern fully reclining dental chair with a post supported dental light and centralised suction. The cabinetry is all built in to each individual module which is equipped with full hand instrumentation as well as a Cavitron ultrasonic scaler. Audio-visual teaching units are also employed and a variety of teaching material is used employing this apparatus as well as using instruction models and illustrated booklets. Much of the oral hygiene teaching is of course done with the patient using his or her mouth as the model and at the first appointment a full medical and dental history sheet is completed which remains within the patient's notes. Every patient also signs at this stage to say that their dentist knows and approves of their visit or that they have no dentist to whom they regularly attend. The dentist in charge inspects all patients before they commence treatment so that the prescribed treatment from the patient's own dentist can be followed out.

The diagnostic x-ray service which may be used independently of the oral hygiene service is manned by a qualified radiographer who can be instructed by a referring practitioner should he wish to have some special view taken pertaining to his own particular branch of dental surgery. Finished x-rays can be sent at short notice or the patients can take them back to the dental surgeon almost immediately since the Siemens Pantomat P10 automatic processor produces dry x-rays of a high quality within minutes. The x-ray apparatus itself consists of an SS White 90 kv long beam tube head for intraoral films using the Rinn XCP system, and a PANEX Elipso Pantograph which also has a Cephalostat attached so that panoral films can be produced as well as cephalostat films which are especially useful to orthodontists. This x-ray service is especially useful in

an area like Harley Street, London, where hundreds of doctors and dental surgeons consult in a relatively small area of streets and many of these do not have full radiographic facilities available within their own offices, or may not have the time or the staff to produce good x-rays at short notice. Over the last three months a number of dental surgeons both in the immediate environs and also from the suburbs have begun to use the Centre as an extension to their own practice so off-loading the time consuming task of maintaining the enthusiasm of their patients towards the care of their own mouths. Throughout the past weeks there has been a constant flow of dental surgeons, doctors and academics from both England and overseas to visit the Centre and already patients are being referred from abroad; it is felt by some dental surgeons that if their patients are visiting London or temporarily resident in London, they should have regular preventive care while maintaining allegiance to their own practice wherever it may be.

All in all it can be seen that this is an exciting new concept in providing preventive dental care, and perhaps if clinics could be set up making full use of ancillary staff a more comprehensive primary dental service could be provided to the community which would also be more cost effective. The question must be asked why 40% of our population do not attend a dental surgeon and fear must rate highly as one of the reasons. If the concept of preventive dentistry could be made known to the public with a massive advertising and information campaign then in the long term this form of treatment which does not involve drilling and filling should make the average dental visit less formidable for the patient of the future. What we surely need is to follow the lead that these practitioners have given and both Dr. Lawson Baker and Dr. Newbury would welcome any Guy's dental surgeon or doctor who would like to visit the Centre and learn more about the services available.

AN ANALYSIS OF 100 CONSECUTIVE, ACUTE ADMISSIONS TO THE EVELINA CHILDREN'S DEPARTMENT

by Camilla H. Haw

Summary

Analysis of 100 consecutive acute paediatric admissions to Guy's Hospital between 8th November 1977 and 11th December 1977 showed 12 to be primarily of a social nature. Many others had a strong social content, though on balance they were deemed to be first and foremost medical problems. 66% of patients were brought direct to the Casualty Department by their parents.

Social admissions would be better dealt with away from the tense setting of a busy medical ward. The creation of a separate ward for these cases is advocated.

Introduction

A recent survey at the Nottingham Children's Hospital[1] indicated that over 20% of acute paediatric admissions are of a "social" nature, that is, they were not medically necessary. It was deemed of interest to study the situation in a London teaching hospital, although it was realised from the outset that the two surveys would not be strictly comparable.

Materials and Methods

A prospective study was carried out of the 100 acute admissions to the Evelina Children's Department between 8th November 1977 and 11th December 1977. Medical staff were asked to complete a brief questionnaire at the time of clerking each patient. This was designed to obtain details of the mode of referral, number of previous admissions, parental age and nationality, housing, Social Security payments, etc. Unfortunately, it proved impossible to enlist sufficient support from the junior medical staff and few questionnaires were filled in. However, in every instance a medical opinion was obtained as to whether the admission was medically necessary or primarily for social reasons.

A medical admission was defined as one where the care required was greater than that reasonably expected of competent parents, for example, nursing observations or intravenous therapy.

Statistical evaluation was carried out with the standard error of the mean test and the χ^2 test as applicable.

RESULTS

Medical or Social

12 of the 100 children were admitted primarily for social reasons. In many other cases poor housing, lack of parental care or supervision had contributed to the patient becoming ill enough to require admission, e.g. several of the poisonings, burns and scalds and respiratory tract infections. Two children were admitted twice during the period studied, on both occasions for medical reasons.

Diagnosis

See pie chart. 28% were admitted for a wide variety of illnesses, e.g. thrombocytopenia, febrile convulsions, gastroenteritis, U.T.I. There were 6

poisonings. The agents involved were aspirin (2 cases, including one deliberate over-dose by the child), prescribed drugs (3 cases: metoclopramide, digoxin and lomotil), and in one case a proprietary embrocation.

Route of Referral

	%
Parents	66
G.P.	17
O.P.D., Infant Welfare Clinic	9
Ambulance, 999	4
E.B.S.	4

Age Distribution

The mean age for the 100 admissions was 4.2 years. 61% were under 5 years of age. 7 of the 12 social admissions were less than 6 months of age.

Housing

85% of admissions live in Council houses as against 12% in owner occupied accommodation. All 12 of the social cases inhabited rented property.

There were many unprompted complaints about the inadequacy of Council houses, in particular about dampness, leaking roofs and insufficient heating. Sometimes there was just one fire in the whole house. Unfortunately, the data collected concerning sleeping arrangements was very incomplete but there were several cases of four and five people sleeping together in the same room. It would be informative to investigate this further.

Where do they come from?

Admissions were widely scattered throughout the catchment area and beyond but the predictable clustering on and around Jamaica Road and on the notorious Aylesbury Estate was noted.

Social Admissions

The main reasons for admission of each of the 12 social cases were as follows:—

Medical Reason	*Social Reason*
1. Thrush	Past history of NAI, maternal distress
2. Allergic dermatitis	Moving house, 17 year old mother
3. URTI, FEEDING PROBLEMS	Past history of NAI
4. URTI	Poor housing, requested by G.P.
5. Diarrhoea	Poor housing, maternal depression
6. URTI	Poor housing, father in prison
7. URTI	*Domestic turmoil!*
8. Feeding problems	Unmarried 17 year old mother,
9. URTI	overcrowded accommodation
10. Infected B.C.G.	Poor housing—one fire in the whole
11. Chest pain	house
12. Abdominal pain	Lack of maternal care and hygiene
	Parental pressure
	Psychopathic mother

There were no admissions on purely social grounds—all presented under a flimsy medical veil. In 3 cases an upper respiratory tract infection was combined with poor, damp housing.

Birth Weight

Only one out of eleven children was of low birth weight or had suffered any neonatal problems.

Marital Status

Only three were known to be married and not separated.

Social Security

Six out of seven were receiving payments.

Number of Previous Admissions	*Medical*	*Social*
% of first admissions	57	50
Mean no. of admissions	1.2	1.5

Two of the social cases had had multiple social admissions in the past.

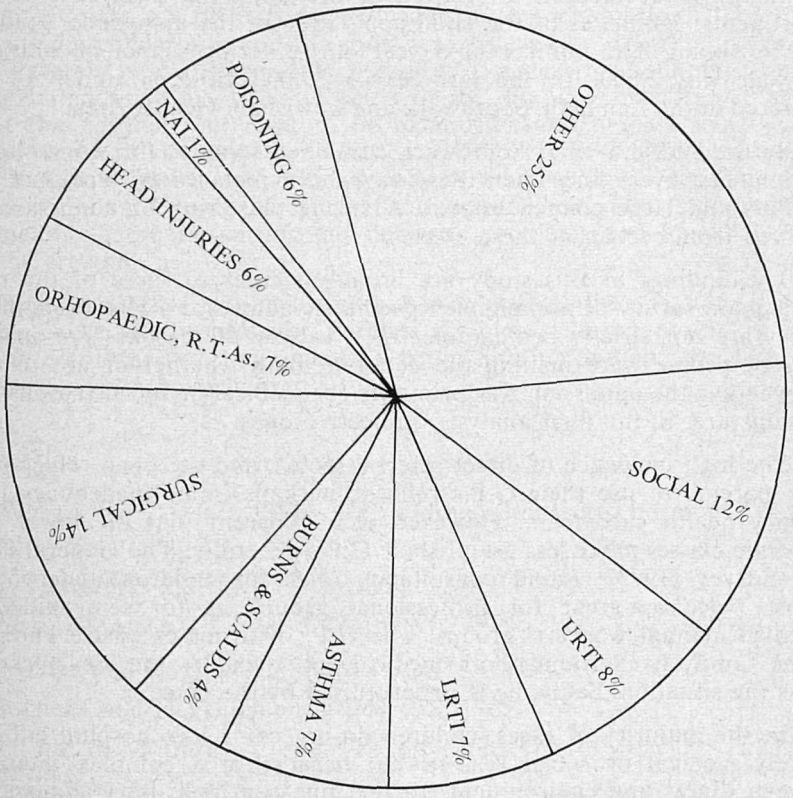
Number of Sibs	*Medical*	*Social*
Mean no. of sibs	1.5	1.7

There was no significant difference between the two means or from the expected number based on Table 5 in reference 1 ($\chi^2 = 3.86$, $\nu = 5$, $0.5 < P < 0.7$ therefore not significant).

Mean Length of Stay	*Social*	*Medical*
Mean length in days	5.9 ± 7.6	6.6 ± 8.8

There was no significant difference between the two means.

The mean length of stay for all paediatric admissions, both emergency and routine, in 1977 was 7.9 days.



Pie Chart of Diagnosis at Time of Admission

Discussion

The results of this survey show that 12 out of 100 acute admissions were primarily for social reasons. In many instances officially medical cases had a strong social flavour and this had often indirectly caused the admission; e.g. lack of parental supervision and burns and scalds, damp housing and respiratory tract infections, immature and unrealistic parents and child abuse. There were no pure social admissions; instead all 12 presented under the guise of some trivial medical condition such as an upper respiratory tract infection or a nappy rash. These social cases were predominantly children under 6 months of age and it was often their first admission to hospital. However, two children had a long history of social admissions. There was no association with low birth weight or neonatal distress as has been observed with NAI. Many came from young, single parent families or from a background of marital disharmony. Existence on Social Security payments was also a commonly occurring feature.

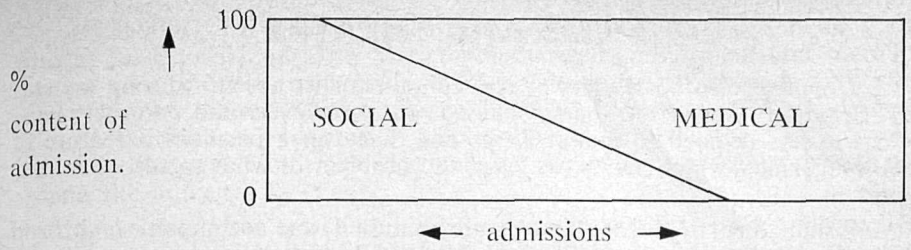
During the last 12 months there were 2,200 admissions, both routine and emergency, to the Evelina Children's Department[2]. Guy's catchment area for acute admissions is a roughly triangular region bordered by the Thames on its northern aspect and by the Health Districts of King's and St. Thomas' on the other two. Some admissions came from outside this area and there is considerable overlap with the adjoining paediatric casualty departments. Estimates of the child population of the area under study are hard to obtain. The number of 5 year olds entering school in Southwark last year was 2,800. In the last census 29,000 children under 14 were registered in the Lambeth, Southwark and Lewisham Health Area.

Before World War II Southwark contained some of the worst slums in London. However, since then these have been replaced by blocks of high-rise flats and large council estates. A strong clustering of admissions was observed from certain of these estates.

The findings of this study are broadly similar to those of the recent Nottingham survey of non-planned paediatric admissions. However, the two studies are not strictly comparable for a variety of reasons. For instance, different people were making the decisions both whether or not to admit and whether the admission was primarily for medical or social reasons. Both decisions are, in the final analysis, subjective ones.

The high incidence of direct referral (66%), and the open reluctance of these parents to use their G.P.s reflects, perhaps, some inadequacy in the primary health care team. However, it is apparent that the lower socio-economic classes make less use of their G.P.s generally. The General Household Survey (1973)[3] found consultancy rates for children under 5 were almost twice as great for professional groups as for semi-skilled and unskilled manual workers' groups. The G.P., with his extensive knowledge of the family background, both medical and social, is the ideal person to assess the situation. Sadly, he is underutilised by the poor.

In the majority of cases, children do not come into hospital either for entirely medical or social reasons but because of a complex interaction between illness and environment. In fact one can look upon admissions as representing a spectrum . . .



. . . rather than being rigidly "social" or "medical". Several studies [4, 5, 6] have linked illness and disadvantaged children. This analysis of individual admissions bears out these findings. The incidence of many types of illness such as infections, particularly respiratory tract infections, home accidents, T.B., infectious hepatitis and meningitis can almost be seen as an index of poverty.

The traditional and established rôle of the hospital has been the care of the sick and as medical science advances the techniques of diagnosis and treatment are constantly reaching new heights of sophistication. Hospitals are expensive places—the cost of a bed in Guy's is approximately £345 per week[7] (figure for 31.3.77). They are not orientated towards the care of the physically well but disadvantaged child. However, there is an increasing acceptance of the use of hospitals as hostels in the prevention of threatened or impending child abuse and the short term alleviation of stress in families with a severely handicapped child. As there is a dearth of suitable alternative accommodation available 24 hours of the day, it seems likely that the rôle of the hospital will have to be extended to encompass social cases. Perhaps these children could be better helped by the creation of special wards staffed by social workers and doctors working in close co-operation with the G.P.s, housing department, health visitors etc. Thus, opportunities for educating mothers, sorting out domestic problems and financial crises would be created.

However, all these are measures aimed at treating the effect and not the probable causes of the problem. Perhaps the biggest improvements in child health in Southwark could be made by better housing and educating parents as to the needs of their children.

References

1. J. Wynne and D. Hull, "Why are children admitted to hospital?" B.M.J. 1140 1977.
2. Guy's Hospital Statistics Department.
3. General Household Survey (1973) H.M.S.O.
4. P. Wedge and H. Prosser, "Born to fail?" (1973).
5. National Child Development Study 1958-1969.
6. "Fit for the Future" Committee on Child Health Services H.M.S.O. 1976.
7. Management Accounts, Guy's Hospital.

FILMS AND THEATRE

I apologise to all readers of this column for its absence during my stay in Brighton. Far from being phased out, however, the infinitely wise *Gazette* has decided to make 'Films and Theatre' a permanent feature of the magazine—which solves, at least, the problem of what to roll your next joint in.

I shall turn to theatre first of all because I was accompanied up from Brighton by a play that will please hardy Pinterian perennials, and also amuse those less addicted to the writer; The **'Homecoming'** by Harold Pinter (Garrick Theatre).

If Pinter had painted the Mona Lisa, she would have had a patch over one eye, while intimating to the observer that the covered eye was entirely normal. Such are the antics of this extraordinary playwright, who appeals to our cosy, liberated society of Behaviourists in a way reminiscent of the Victorians' fascination with dirty postcards. Incidentally if you wish to be a liked and respected member of the general public one day, you must never ask what a Pinter play (his name has become a household adjective) is about. For as Mr. P. revealed in a recent interview on television, while he chain smoked and drank away the confusions of the world, the great man, himself doesn't know what they are about.

A homecoming sounds like a cheerful occasion, and the characters would have said no doubt that it was. Yet in Pinter's hands, where nothing and nobody are as they seem, it becomes a ghoulish affair. His people live by self-deception, serviced by their inability to listen to each other, and the seemingly successful ones among them are either failures or crooks. For instance, the father of the family is always referring with loving admiration to a friend of his as McSomething or other, who inevitably as it turns out, had his wife in the back of his brother's taxi—a fact which the father is quite unable to accept. The actors utter phrases and sentences at each other but there is no empathy because Pinter has systematically (with very explicit stage directions) omitted all those nods and winks and silence fillers, the sleasier side of humanity and plenty of twists, helps to confuse the audience to the extent that they can no longer believe what the actors say, and try to work out instead why they are saying what they are saying and of course there is no pattern to be found there either. In that he deals constantly with the theme of how fragile communication is both within a person and in his interractions with others, Pinter is nevertheless telling us something about the world that we live in. The play has, for Pinter, a moderately intelligible plot and is very funny in parts, and together with some remarkable acting it provides a rather special feast.

If you just want a good laugh, however, there is plenty of choice at the moment in theatre land. **"Dirty Linen"** by Tom Stoppard (Arts Theatre) is the story of the meeting of a House of Commons committee on sexual mores in the house, where each member of the committee is, as it turns out, an offender against those mores himself. That, apart from flying panties, and the Prime Minister being fond of Tennyson is just about all that the play is about. Yet it is extremely funny. The person sitting next to me, I should say, felt that he had been robbed and it was just possible to understand his point of view during a strange 20 minute interlude in the middle of the play, which Stoppard can only have written drunk, while in the bath, and being tickled.

Alternatively, if you're young and trendy and want to shock your straight laced girlfriend, or if you're middle aged and straight and want to impress your mistress, you could do far worse than to go and see **"The Rocky Horror Show"** (King's Road Theatre). Appropriately situated in Chelsea, the show is a take off of a lot that goes on down the King's Road, but mind that you don't get attacked by one of the monsters that roam around the audience.

Many good films are currently on offer and the next issue will provide a more comprehensive review of them. **'Julia'** (Odeon, Haymarket) starring Vanessa Redgrave, playing a romanticised version of herself, and Jane Fonda, is about the relationship between a determined aristocratic English girl, and an American girl, who is constantly battling to keep up with her. Julia's early self-confidence and strength of will are later expressed in concern, and then active participation in the events of pre-war Europe. Meanwhile, Jane Fonda, who has become a successful writer arrives in Europe to find that she is required to carry out an important mission to further Julia's work. The result is a very exciting film, which provides sensitive glimpses into the differing personalities of both women, without being sentimental. If your appetite was whetted by seeing Diane Keaton in Annie Hall (Filmcenta, Charing X Road), you will be pleased to see that she is currently starring in her usual beautiful, charming and neurotic way in **'Looking for Mr. Goodbar'** (Plaza, Picc. Circus and Sherlock Holmes Centa, Baker St.). The original plot concerns an altruistic teacher of deaf children, by day, who obtains her oats by rather unconventional means at night. Which might, you would say, give Miss Keaton an excellent opportunity of showing the deep conflicts and other contradictions that are implicit in such a situation. Instead she continues to be beautiful, charming and neurotic in a light hearted way, and makes the film rather more of a comedy than a tragedy. Nevertheless there are pay-offs; the film is full of suspense and you will see as much of Miss Keaton's body as you are likely to ever see again.

Finally, there are a couple of nice oldies on show. **'The Sting'** is also on at the Plaza, Piccadilly Circus, if you can't get into the last film, with Robert Redford and Paul Newman acting elegantly to the music of Scott Joplin. You could also see the best film of 1977, **'Network'** (Odeon Lewisham/Wimbledon) which was Peter Finch's last and best film, and which depicts the ruthlessness of a television company, which is prepared to go to any lengths to keep its viewers.

Michael Dixon.

NURSING

The Need For Change

Those people who have worked for a fairly long period in the Health Service, cannot have failed to notice the fact that over recent years there has been a marked increase in the workload combined with a decrease in nursing staff numbers. These changes have, in part, been precipitated by economic factors, but in the case of the latter, there has also been a depletion in numbers as a result of the shortened working week, and the fact that many patients require more intensive care than was previously the case.

The outcome of this has been the failure of many units to give safe and adequate care to patients, and their refusal of treatment to others. Unfortunately this situation has been exacerbated by medical colleagues. They are, for the most part individualists and consequently somewhat self-centred. Each consultant is interested only in his speciality and has no wish to consider the needs of others. This means that unreasonable demands are being made on nursing services by egocentric empire builders who think only of their own interests. Doctors on the whole make worse managers than nurses, and do not appreciate the finer points of delegation or distribution of resources; nor indeed have they any wish to become familiar with them. As a result of all this unprecedented demands are now being made on nursing services, and this has caused a lowering of morale in the profession.

However, there is another aspect to this situation. It is true to say that the lowered morale is due to the nurses conviction that they are giving inadequate care, but what, one may ask constitutes a high standard? In many instances, nurses are setting their standards on those of thirty or more years ago. The training syllabus of the General Nursing Council is still based on these criteria and is now for the most part outdated. No one has given any consideration to the thought that some revision of ideas might be justified. Ward routines have barely seen any changes during the past twenty years, despite radical alterations to working hours and the times at which maximum numbers of staff are available. Ward Sisters still insist on asking for the majority of work to be undertaken in the morning which nowadays is the period when there are least people available to complete it. Sadly too, it is the youngest of these who are the most inflexible, but this is probably due to their lack of experience.

It is surely time that nurses took a look at their work and considered how best they can adapt to the needs of today, instead of bemoaning the fact that the methods of more than a generation ago cannot be continued. It would also be a salutary experience for the doctors to do likewise. One cannot continue without change in a changing world and it would behove the ever rigid nursing profession to look closely at themselves, make some constructive critcisms and then act upon them.

Pam Jeffries.

PHYSIOTHERAPY

Paramedical Staffing

Someone observed the other day that one cannot run a specialised unit on a five-day week cottage hospital basis, and that it is ridiculous not to have enough staff to be able always to have people who know what they are doing and to whom they are doing it. He was talking to physiotherapists and so related his remarks primarily to them but he brought other associated paramedical and junior medical staff into the same category. I imagine we would all agree that general as well as special units would be better served by increased numbers of more experienced staff all of whom knew all the patients—as long as we could persuade them to leave the patients alone long enough for them to recover on their own.

We really need a touch of Solomon to enable us to judge where best to deploy our staff, though to threaten to bisect all the physiotherapists might not be too productive. It is perfectly proper for each specialist to feel that his patients are more treatment-worthy than the next man's, and one would expect him to press for the best service for them that he could obtain, but he must know that others are able to produce equally persuasive arguments—when taken in isolation.

How is the allocation to be made then and by whom? Until comparatively recently the answer would probably have been as a result of lobbying the Physical Medicine Consultant, who might have discussed the matter with his superintendent physiotherapist or might have instructed her, in his capacity as Departmental Director, in the disposal of her staff. Now, it is not so simple, for in the same way that physiotherapy departments budded off from nursing establishments and matrons relinquished their control, so have they emerged to a greater or lesser degree in different settings from under the wing of the medical staff, and become essentially autonomous—even if metaphorically mixed.

This is a situation regarded as natural and inevitable by some, as abnormal and undesirable by a few and as nothing to be bothered about by most. However, some of those consultants who make the biggest calls on physiotherapists and allied workers are interested in setting up ad hoc "user" groups in which potentially conflicting interests can be brought together and, it is hoped, reconciled. The alternative, of course, is for the superintendent physiotherapist, or whatever, to make the decision and while, I would guess, the great majority of medical practitioners would not wish to become too immediately embroiled in the running of paramedical departments, it may well be that there are fewer who would contemplate with equanimity the head therapist alone deciding on the size of the slice of therapeutic cake that each speciality will receive.

It is an important stage in the development of the "professions supplementary to medicine" and it will be interesting to see what local variations arise—or indeed to see if national directives rather than flexible guide-lines will be laid down.

Ronald Cooper.

BOOK REVIEWS

"The Drugs Handbook" by Paul Turner and Glyn Volans. Pp. 170. Price £4.95. Published by Macmillan.

This little volume is intended to help those in the ancillary professions allied to medicine such as radiographers, dieticians, social workers and the like, whose work brings them into contact with patients taking drugs. Its aim is to help in the understanding of the nature, purposes and side-effects of the drugs which doctors prescribe. The book could also provide a quick and ready reference for nurses to consult before the drug round. It consists of a brief introduction which simply and lucidly defines the technical terms used in pharmacology, followed by an alphabetical index of all the drugs which are commonly given to patients. Their uses and side effects are defined in a few sentences. A separate index lists trade names and the components of combination preparations thus allowing easy cross-reference. As would be expected from these authors, the text is right up-to-date and includes the most recently introduced drugs such as cimetidine and labetalol. It should prove extremely useful for its intended readership and may help our ever hard-pressed secretaries to spell correctly the name of an unfamiliar drug heard indistinctly on the dictaphone.

HOWARD ROGERS.

"Psychiatry for Students" by D. Stafford-Clark and Andrew C. Smith. Pp. 333. Price £6.50, paperback £3.95. Published by Allen and Unwin, London 1978.

This is a most interesting book. It illustrates how textbooks develop, evolve, or are useless. It is not the same as previous editions, but clearly has affinities with them. It bridges the span between the time when Dr. Stafford-Clark was Director of the York Clinic and the period since 1974 when the Medical School's Department of Psychiatry was founded. The link is Dr. Smith, who is a member of my Department and used to be (before such persons were referred to as "in higher training") First Assistant to Dr. Stafford-Clark.

Those who know Dr. Stafford-Clark's characteristic style of earlier editions will find it in this one, though abated. Those who know Dr. Smith's breadth of learning and eclectic clinical sense will find signs of these. The Smith style blends happily with the Stafford-Clark style and will doubtless develop more autonomy in future editions.

The content of this book is sound. I hope Dr. Smith will consider (a) giving up the term "reaction" in the definition of various disorders (hysterical, psychosomatic, etc.), (b) defining "stress" as life event when it means life event and as particular responses when it means these ("stress" can refer to either or mean nothing definite at all), (c) locating his system of classification within the I.C.D. and (d) add what some might call more sensible psychological leaven to the psychoanalytically based account of personality development. But these are personal hobby horses and are minor points. I think Curran Partridge and Storey is the only serious rival I have come across as a student text book; and the paperback version is excellent value at today's prices.

J. P. WATSON.

"Gaddum's Pharmacology" by A. S. V. Burgen and J. F. Mitchell. Pp. 269. Price £4.50. Published by O.U.P.

Gaddum's Pharmacology in its revised form has been written by two distinguished pharmacology teachers and research workers. As might have been predicted this new edition is, like its predecessors, brief, crisp and up-to-date. A new (and non mathematical) chapter has been put in on pharmacokinetics, and there are succinct and useful statements on such substances as encephalins, prostaglandins, levamisole and cimetidine.

Some clinicians may argue about some of the more applied aspects of the text. For example in the section on hypnotics is written, "sleep is as necessary as food, and lack of it is a serious complication of disease". Also following this, the barbiturates are given perhaps an over prominent place in the description of the individual drugs. Another small point of criticism is that the use of sodium valproate (called "valporate" in the text—with the wrong formula as well) in treating a wide range of types of epilepsy is not mentioned. But this book is aimed at preclinical students and is an admirable summary of basic pharmacology.

R. G. SPECTOR.

CORRESPONDENCE

The Preclinical Biochemistry Course

Sir,

I feel it necessary to comment on the remarks made by Professor Diplock in the April *Gazette* regarding the above course. He expressed the thought that he would rather see the course evolve, instead of being subjected to drastic upheaval. Reviewing the present Guy's course in Biochemistry, it would appear that since my own year started that course over $3\frac{1}{2}$ years ago, the format of the course has not evolved at all, unless you consider the introduction of a practical on alcohol tolerance to be a significant change. Is this length of time not long enough to "test the flavour of the pudding"?

On the question of relevance to Medicine, Professor Diplock may be interested in the following results from a S.M.E.C. survey on student opinion in 1974 (repeated in 1976). To the question "How much of the course taught in the following subjects is relevant to Medicine?", 75% of students in 1976 and 77% in 1974 thought that the Biochemistry course had little or some relevance to Medicine. Although students are inexperienced in planning and assessing such courses, this is no reason to disregard their criticisms, and figures such as those I have just quoted would suggest that something is lacking in the course. It is pleasing to see that members of S.M.E.C. are involved in present discussions about the course and I still maintain that the time is ripe for some major changes in the course, especially with respect to the practicals. Perhaps these discussions will bring about these sorely needed changes.

Yours faithfully,

WESLEY SCOTT-SMITH.

Boland House,
Guy's Hospital,
London, S.E.1.

Houlding up the Bar

Sir,

Neil Matthews, the Bar Secretary, finds it insulting (see his article 'The Continuing Saga of the Bar') that people continue to cast aspersions on his staff despite the persistence of the quite amazing losses suffered in recent months.

I find it insulting to think that he should be so reactionary to the quite justified questions that people are raising concerning the whereabouts of the missing cash. Surely as far as the bar is concerned the explanations are limited to one or a combination of the following:

1. Frank stealing of cash from the till, or pocketing money for drinks as people pay for them.

2. Gross exaggeration of measures, both for shorts and halves; the electrical pumping system may have made a contribution to this.

3. Stocks being lifted before reaching the bar.

4. Free drinks being distributed to 'friends' or over enthusiastic taking of free drinks by the bar staff for themselves.

Unless Mr. Matthews can suggest an alternative route by which amounts of between £600 and £900 per month are deserting the bar funds, then he must face up to the prospect of a crooked set-up.

Nobody likes working under the suspicion of theft, particularly if innocent, but surely a more exacting monitoring of drink distribution against turnover would reveal a little more about which evenings the system is being particularly abused.

I suppose the real answer is to hire three impeccable professional bar-men, pay them £300 a week each and then the monthly losses would at least be predictable.

Yours faithfully,

TIMOTHY HOULDING.
St. Stephen's Lodge,
Hankey Place,
London SE1.

The Bar Secretary replies

Sir,

In answer to Mr. Houlding's letter, I find myself surprised by the suggestion that I am being reactionary to "the quite justified questions" people are asking about the losses. This is simply not the case; everyone wants to know where the missing money is going and no one more so than myself I assure you. Perhaps I am reactionary over blatant accusations pointing suspicion at people who are unable to defend themselves, i.e. the bar staff and/or the bar steward when these accusations are made without evidence —surely that is not being unreasonable?

1. Frank stealing from the till? No. If this were the case the sums on the till roll would not match the sum in the till when the two are compared.

Not ringing up the taking? Well, that is possible but let's look at it logically. Assuming that **every** member of the bar staff was dishonest they would each have to pocket about £10 per night and this is difficult to do without being seen. But how likely is it that they are all crooks? If we then assume that only a few are thieves, these nefarious characters would, on the one or two nights a week that they work, have to pocket about £50 each—virtually impossible I think!

2. Exaggeration of measures. Again possible. However can anyone suggest a reason why the bar staff should serve free drinks to any Tom, Dick or Harry who comes to be served—it doesn't make sense, and assuming that only friends of the bar staff are privileged in this way they would have to be artists indeed to get through that amount of free booze every night. As for electric pumps, well I myself pointed out that these are probably losing us money and if I may digress for a moment I am pleased to announce that the Secretary of the Medical School is, at present in the process of getting rid of these wretched machines and we hope they will be gone by the middle of June.

3. Stock being lifted. Unlikely for the simple reason that our monthly stock-take would reveal if such large amounts of stock were going—yes Mr. Houlding we do monitor our drink distribution you see.

4. Free drinks to friends—merely a repetition of item (2) so let's not waste any more time on that.

Free drinks to bar staff—could be, but £10 worth per night each—when was Mr. Houlding last served by an utterly blitzed and intoxicated barman?

Furthermore I worked behind the bar every night during April and saw no evidence of heavy drinking or stealing amongst the bar staff so I do at least have some grounds for defending the bar staff which is more than Mr. Houlding and his kind have for attacking them.

So now we come to Mr. Houlding's "answer" to the problem—well I don't think that facetiousness ever solved a problem and in addition if any one can find us a barman whose integrity can be proven any more conclusively than that of the present bar staff then we will consider hiring him.

In conclusion to my reply I would like to point out that all Mr. Houlding's suggestions have been thought of, written about and considered before and it appears that his plagiarism is intended solely to take a dig at me and the bar staff. Frankly his letter does little apart from disappoint me with its destructive criticism and bore me with its lack of originality.

Yours faithfully,

NEIL MATTHEWS.

The Hockey Club

Sir,

I am writing concerning an article about the football club in your recent edition of the *Gazette*.

It was an interesting article that was unfortunately spoiled by some rather snide and irrelevant remarks about the Rugby and Hockey Clubs.

I would like to offer the football club my sincere congratulations on their successful season but feel it is a sad moment when one club has to cast aspersions on the activities of other clubs that are for the time being less successful than themselves. I would conclude by saying that perhaps this is the kind of support one comes to expect from participants of a "working class sport".

Yours faithfully,

DAVID A. HETT,

pp. "The Anonymous Hockey Club".

SPORT

This is the last Brighton report from your roving super-correspondent, Bore of Billericay. Last week on the south coast occurred an interesting end of the season rugby match. The young doctors of the R.S.C.H. in Brighton were due to climax their season playing Hove seconds team (and friends). The game was not played to Cardiff Arms Park standards, but provided light relief to the scattering of spectators and afternoon strollers.

It is seldom a clever idea to arrange rugby matches in late April and this fixture proved no exception. On this glorious sunny Sunday afternoon the players assembled. The ground looked like a desert, no grass but cracked and rutted; many of the doctor's team looked equally rough. Sunday is also not often the best day for exertion—shown particularly by the fact that part of the doctors' team didn't appear. Several of the largest bystanders were selected to form a scrum. With the rest of the positions decided and a referee elected the teams were ready for off.

It soon transpired as the game progressed that the doctors had a vastly superior threequarter line and could waltz through opposition ranks with ease. With not a little sense of relief they trotted around taking it in turns to score and include as many complicated manoeuvres as possible. The makeshift pack led by the energetic Fitzgerald-Frazer who never seems to get his hair ruffled or be found at the bottom of a ruck, battled eagerly, although it must be said avoiding physical contact where possible. That part of the pack recruited from the touchlines did a great deal of the dirty work, whilst the regulars provided a back row which left scrums at great speed, and included a tall thin visiting medical student who won a lot of balls from the line outs but kept crumbling in the scrum and complaining his ears hurt and that people kept treading on his toes. The hooker of the team was Greg Earnshaw, an old and celebrated Guy's man, notable for his inability to hook. He managed to strand himself on the flat roof where an enterprising fullback had tactically hoofed the ball. After somebody got him a ladder he returned to the game and was unwise enough to attempt a slightly high tackle on their six foot six giant who handed him off about three feet into the air. Greg's hooking was marginally better after this.

In the second half, a lead well established, the doctors settled for a kick and rush approach. This only led to a series of injuries to their lighter team. One eager forward attempted to inhale his gumshield and this made his nose bleed rather a lot. Another high flyer was hauled from a particularly vicious looking maul looking a little dizzy but he played on. About five minutes later he explained to the captain that he thought he ought to stop playing as however hard he tried, he couldn't remember where he was supposed to be playing. The remainder held on with the backs scoring less frequently and the goal kicker maintaining his one hundred per cent failure rate. After his ninth miss, he looked as if he might cry, so the backs sportingly decided not to score again for his sake.

During the post match refreshments the concussed forward regained his memory and became quite lucid. Later on, however, he was found telling a night sister that he was "Merv the swerve" and needed admitting. He probably did, it was one of those days.

BRIAN BORE.

SOCCER

End of Season Review

At the time of publication of last months *Gazette* the final league situation was not known. However, it is now my great privilege to announce that the 2nd XI *won* their league, and subsequently promotion to Division 2R, with a total of 36 points from 22 games—one more point than Barts could muster.

This fine achievement was clinched in the last game of the season when we thrashed Chelsea 12—4. 10 of the goals being shared by the incorrigible Underwood brothers.

After such a successful season, in which we also finished runners up in the United Hospitals cup, it is now time to reflect on some of the individual performances in what was a total team effort.

Behind the safest defence in the league —only 30 goals were conceded in league games (who's Nott's. Forest anyway?) we had Robin Evans in goal for his 3rd successive season, and a remarkably consistent one at that. At least I can't

remember him once throwing the ball into his own net or allowing it to pass between his legs.

The achievement of the back four was all the more remarkable when one considers it was completely made up of new members to the side.

At right back, Harri Williams developed into the most improved player in the team and certainly the keenest; for he came all the way back from Wales to play the last game.

At left back, Mark Batterbury was marvellously skilful on the ball and his overlapping contributed much to attacking moves. His skill was rewarded with a number of 1st team games, but I feel he would be even better if he was more inclined to head the ball.

In the centre of defence we were lucky enough to have for most of the season the supremely solid Dave Abraham, who managed to score with just about every part of his anatomy except his foot.

His partner was mainly Liam Broughton, who started the season in midfield, even moved up to right wing for one game, before finding his best position at the back where he had more time to use his vision in setting up attacks from the rear (much to opposing centre forward's intrepidation).

Garry Calver was always a ready reserve capable of filling any of these positions and could always be relied upon to give nothing less than 100%.

The midfield seemed to be the critical position for much of the season. If this department was playing well, the rest of the team seemed to respond that much better. This zone was normally occupied by Tim Miller, Dave Greenaway and Roger Davies, although it was here that competition for places was highest and Alex Williams proved to be a very promising player. Whatever the combination, the football was generally fluid and resourceful, and at times delightful to watch.

Tim Miller, in his last season, never seemed to stop running, playing close, tight football in the way only he can, and Roger Davies showed that his 2 years in goal for the 1st XI had not blurred his fine positional sense and skilful distribution, even if it did affect his stamina at times.

The forward line of Graeme Smith, John Rawcliffe, and Keith Underwood had the unhealthy look at the start of the season of three wingers and no centre forward. However, John Rawcliffe made the position his own and was top scorer with 22 goals. Fast and powerful, John is essentially left-footed, but when in full stride is very difficult to shake off the ball.

Keith Underwood had a fine season as captain of the side scoring several spectacular goals from the left with first time shots.

Graeme Smith scored less goals than these two, but his pace down the right-wing and accurate crosses were the supply line of many goals.

Thus, the football was nearly always enjoyable, and the beer afterwards was never anything else. There was always a fine spirit in the side and this was typified last week at the U.L.U. Annual General Meeting.

The League Secretary proposed a motion to shorten each reserve division, which would have meant us remaining in 3R. No less than 6 members of the club were present to push an opposing motion to the vote, which was successful at the Second Ballot.

With this kind of spirit in the Club the unlikely Plaid Cymru combination of Roger Davies and Harri Williams can only have further success in the higher division next season.

DAVE GREENAWAY.

CRICKET CLUB REPORT

22nd April–14th May

The first month of the cricket season has been most disappointing from all aspects. The first eight games all had to be cancelled due to rain; the sort of subaqua conditions we have at the moment make one feel that the Russians in their incessant campaign to subvert English cricket and many other lesser causes must have diverted the river Ob and extended the Polar ice cap nearer to our shores. Because of this also, no proper pre-season net practice has been possible.

However when we did manage to play a game, against Thornton Heath in the 1st round of the Bertie Joel Cup our performance left plenty to be desired.

Batting first on a damp wicket which would have cut up if we had given it time, we were bowled out for a mere 43, mostly due to a series of shots that are best forgotten, although their seamers did receive help both in the air and off the wicket. When they batted Thornton Heath managed to graft the runs for the loss of 1 wicket.

We look forward to some better weather and more practice before the Hospital's cup commences.

ALASDAIR JADES.

HOSPITAL INFORMATION

PAPERS BY GUY'S MEN

Amiel, G. J., 1978, Aspects of Antenatal Care, Update, **16**, 155.

Amiel, G. J., 1978, Blood Testing and the Anaemias of Pregnancy, Update, **16**, 419.

Ashley, F. P. *and* Wilson, R. F. Comparability of the biochemical composition of dental plaque samples collected from 12- to 13-year old males on a "split-mouth" basis. **Caries Research**, 1978, **12**, 173.

Bajorek, P., Widdop, B. *and* Volans, G. Lack of inhibition of paracetamol by codeine. (Correspondence.) **British Journal of Clinical Pharmacology**, 1978, **5**, 346.

Buisseret P. Seasonal asthma in an angler. (Correspondence.) **Lancet**, 1978, **1**, 668.

Chegwidden, R., Rogers, H. J. *and* Spector, R. G. The influence of aromatic amines and folate on acid production by **Escherichia coli**. **Experientia**, 1978, **34**, 497.

Coakham, H. Computerised tomography of the brain. **Practitioner**, 1978, **220**, 437.

Creasy, M. R. *and* Polani, P. E. High risk of Down's syndrome at advanced maternal age. (Correspondence.) **Lancet**, 1978, **1**, 716.

Crome, P., Braithwaite, R., Newman, B. *and* Montgomery, S. Choosing an antidepressant. (Correspondence.) **British Medical Journal**, 1978, **1**, 859.

Crome, P. Ectopic ACTH-secreting tumour of the bronchus and agammaglobulinaemia. **British Medical Journal**, 1978, **1**, 824.

Crossman, I. G. *and* Reed, R. T. Long term results of premolar extractions in orthodontic treatment. **British Journal of Orthodontics**, 1978, **5**, 61.

D'Arcy, J. Pes anserinus transposition for chronic anteromedial rotational instability of 1978, **60-8**, 66.

Douek, E. E. Aids to hearing. (Correspondence.) **Journal of the Royal Society of Medicine**, 1978, **71**, 302.

Feyerabend, C. *and* another. Effect of urinary pH and nicotine excretion rate on plasma nicotine during cigarette smoking and chewing nicotine gum. **British Journal of Clinical Pharmacology**, 1978, **5**, 293.

Fuller, J. H., Pinney, S., Jarrett, R. J. Kilbourn, K. *and* Keen, H. Plasma lipids in a London population and their relation to other risk factors for coronary heart disease. **British Heart Journal**, 1978, **40**, 170.

Gardiner, P. A. Television medicine. (Correspondence.) **British Medical Journal**, 1978, **1**, 715.

Golding, S. Fellowship in medical communication? (Correspondence.) **British Medical Journal**, 1978, **1**, 1056.

Goulding, R. Household products and poisoning. (Correspondence.) **British Medical Journal**, 1978, **1**, 718.

Higenbottam, T., Ogg, C. S. *and* Saxton, H. M. Acute renal failure from the use of acetazolamide (Diamox). **Postgraduate Medical Journal**, 1978, **54**, 127.

Jeffreys, D. B. *and* Vale, J. A. Cimetidine and bradycardia (Correspondence). **Lancet**, 1978, **1**, 828.

Lehner, T. Dental caries and periodontal disease. **Journal of the Royal Society of Medicine**, 1978, **71**, 161.

Lehner, T., Russell, M. W., Challacombe, S. J., Scully, C. M. *and* Hawkes, J. E. Passive immunisation with serum and immunoglobulins against dental caries in rhesus monkeys. **Lancet**, 1978, **1**, 693.

Lessof, M. Immunological reactions in heart disease. **British Heart Journal**, 1978, **40**, 211.

Maisey, M. N. Nuclear medicine. **Practitioner**, 1978, **220**, 445.

Montgomery, S., Crome, P. *and* Braithwaite, R. Nomifensine overdose. (Correspondence.) **Lancet**, 1978, **1**, 828.

Neild, G. H., Cameron, J. S., Lessow, M. H. Ogg, C. S. *and* Turner, D. R. Relapsing polychondritis with crescentic glomerulonephritis. **British Medical Journal**, 1978, **1**, 743.

Parsons, R. L., Beavis, J. P., David, J. A., Paddock, G. M. *and* Trounce, J. R. Plasma, bone, hip capsule, and drain fluid concentrations of cephazolin during total hip replacement. **British Journal of Clinical Pharmacology**, 1978, **5**, 331.

Parsons, R. L., David, J., Paddock, G. M. *and another*. Plasma concentration/Time curve of erythromycin after a 12-hour intravenous infusion of erythromycin lactobionate in man. **Postgraduate Medical Journal**, 1978, **54**, 68.

Pembrey, M. E. *and* others. Natural history of sickle cell anemia in Saudi Arabia. **Annals of Internal Medicine**, 1978, **88**, 1.

Pitcher, D. *and* Mary, D. *Listeria monocytogenes* endocarditis in hypertrophic cardiomyopathy. **British Medical Journal**, 1978, **1**, 961.

Russell, M. W. *and* Lehner, T. Characterisation of antigens extracted from cells and culture fluids of streptococcus mutans serotype C. **Archives of Oral Biology**, 1978, **23**, 7.

Seller, M. J. *and* Berry, A. C. Amniotic-fluid alpha-fetoprotein and fetal renal agenesis. (Correspondence.) **Lancet**, 1978, **1**, 660.

Spencer, J. D., Millis, R. R. *and* Hayward, J. L. Contraceptive steroids and breast cancer. **British Medical Journal**, 1978, **1**, 1024.

Viberti, G. C. Glucose-induced hyperkalaemia: a hazard for diabetics? **Lancet**, 1978, **1**, 690.

Williams, C. *and* Coltart, T. M. Adipose tissue metabolism in pregnancy: the lipolytic effect of human placental lactogen. **British Journal of Obstetrics and Gynaecology**, 1978, **85**, 43.

PASS LISTS

ROYAL COLLEGE OF SURGEONS

Primary F.D.S.

N. W. T. Harradine
Ms J. Kirschen
A. C. Mellor
J. F. C. Schnetler

UNIVERSITY OF LONDON

Ph.D.—Medicine

A. Sita-Lumsden (Dentistry)

Ph.D.—Science

D. B. Campbell (Biochemistry)

ENGAGEMENTS

The engagement is announced of Laurence Jacobs, B.D.S., L.D.S., R.C.S.(Eng.) to Bebe Sober, B.A.(Hons.).

The engagement is announced of Mr. Richard Dunn "(the locum)" and Miss Shauna McLachlan, radiographer from Glasgow Royal Infirmary.

BIRTHS

BAILEY—To Christine and Malcolm Bailey, on 3rd March, 1978 at University College Hospital, London, W.C.1, a daughter, Hanah Mary.

CHANGES OF ADDRESS

Dr. and Mrs. Malcolm Bailey, Pantiles, 10 Upper Drive, Angmering-on-Sea, Sussex.

Mr. D. A. Hogben, 44 Fore Shore, Pepys Estate, Deptford, London, SE8 3AG.

Dr. and Mrs. D. J. Rhodes, The Spinney, Hunts Lane, Felmersham, Bedford. Tel. Bedford 781535.

Dr. Prudence Tunnadine, 6 Lewes Road, Ditchling, Sussex. Tel. Hassocks 2265 (Practice address remains 111 Harley Street, London, W1N 1DG).

Mr. and Mrs. J. K. Donald, Bridge House, Pennance Road, Falmouth, Cornwall. Tel. Falmouth 312 891.

DEATHS

Dr. John Rhys-Herbert, L.D.S., R.C.S. (1919), L.M.S.S.A. (1925), of Anneddwen, Barmouth, Gwynedd, died on April 16th, 1978.

PERSONAL

TIM HOPE-WYNNE, an established Life Assurance and mortgage advisor with Imperial Life Assurance Company of Canada, has been visiting and advising doctors and nurses at Guy's about their financial circumstances in relation to these matters. If you feel you would like his help contact him on 01-937 7292.

WANTED. Part time Dental Surgery Assistant for a regular one day a week in West End Private Practice. Previous dental experience or SRN essential. Suit married woman with family commitments completed. Tel. 01-580 2720.

GUY'S HOSPITAL GAZETTE

ISSN : 0017-5870 Tel. No.: 01-407 7600 Ext. 2023

EDITOR ADRIAN PINI
ASSISTANT EDITOR PHILIP RAZZELL
NEWS EDITORS STEPHEN FENNY and CAMILLA HAW
SPORTS CORRESPONDENT JONATHAN EARNSHAW
NURSING CORRESPONDENT PAMELA JEFFERIES
PHYSIOTHERAPY CORRESPONDENT RONALD COOPER
RADIOGRAPHY CORRESPONDENT JILL GUEST
MANAGER LYN PAYNE

MONTHLY 24 JUNE 1978 VOLUME 92 NUMBER 2283

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

'The E.G.A. Stays—O.K.'

The Elizabeth Garrett Anderson, for 152 years the hospital run for women by women, has been granted a stay of execution. As a breathing space to allow further discussion on its future this should be welcomed. Shrill indeed have been the cries raised in defence of the E.G.A.; loud and alarming enough to result in Mr. Ennal's spectacular reversal of policy. Surely the people to consult now are the customers, for it cannot be disputed that the E.G.A. is practically unique in catering for women whose religion or psychology prevents them from seeking treatment from male doctors.

The broader question of whether women (or indeed even a substantial minority of them), prefer to be treated by female doctors is one which awaits a definitive answer. There is some evidence that public opinion on this issue is in the process of change, vanguarded by "women's lib" and increasingly articulate criticism of the medical profession's dealings with women. Much of this criticism is unfair, particularly the allegation that male doctors sometimes exhibit a cavalier and dismissive attitude toward female patients. Undoubtedly this can occur, but is surely not confined to male doctors, while the victims are not invariably female. As a general criticism this will just not do.

Nor for that matter will the view that male doctors 'don't understand women or their problems'. It is no more a necessity to be female in order to treat dysmenorrhoea than it is to be consumptive in order to treat T.B. Insight, empathy and clinical skills are not exclusively female attributes. But even when we set aside the more colourful allegations of brutality, 'sociological oppression' and male domination over female bodies there remain some uneasy questions concerning medicine and women, about which there are more opinions than answers. For example, has the medical

profession—and by implication male doctors—been concerned enough about the side effects of the contraceptive pill, and how many of the psychoactive drugs prescribed for women are really necessary? Should women give birth at home or in hospital? In this issue the *Gazette* looks at two of these areas of concern, and finds that there may be a case to answer.

So 'The E.G.A. stays O.K.', and now that the shriller voices have died away we might take the opportunity to weigh up 'women's complaints' and reflect upon the views of our customers.

In defence of Guy's Tower

"Typical British workmanship!" has been the not infrequent and heavily loaded comment heard in the corridors, canteens and cloisters of St. Guy's with the news that the Tower chimneys have crumbled. The implication is that as a nation we have not been able to set one brick upon another since the sun went down on the Empire. With each bit of bad news the prejudice is further confirmed, and good news in conveniently ignored. Such an attitude demonstrates a woeful disregard of history. Those among us who harken back to Britain's engineering heyday should imagine themselves in mackintoshes declaiming its greatness on the Old Tey Bridge!

There have always been problems and setbacks with new construction projects—they are neither typical of the present day or typical of British industry. If data were available, and no doubt someone will soon find that it is, I am sure we would find that the building of Stonehenge was no more trouble-free than the raising of the Pyramids, and marred by the same disregard for union rules and good industrial relations. Think what it must have been like to be an employee of the Druids on the windy Wiltshire plain in 1500 B.C.! No convening of shop stewards then, and no tea-breaks—though they probably punished architectural bungles with primitive finality, which has much to recommend it. (By the way, journalistic hacks have always made much of the doubts concerning the uses to which Stonehenge was put, so I must say my bit. My own view, revealed exclusively to readers of the *Gazette,* is that the shrewd Druids wanted to build the biggest conversation piece in the Western World—a prehistoric folly celebrating their *joie de vivre*—and in this they have succeeded admirably).

But there is no need to delve in to pre-history to find examples of teething trouble which have come right in the end. Look no further than the environs of Guy's—London Bridge did indeed fall down once. Or take Big Ben just upstream; symbol the word over of British democracy and sobriety. The original Big Ben (the bell I mean) was cast at Stockton-on-Tees in the early 1850's and was transported to London by sea with great difficulty and through many dangers. It was set up in New Palace Yard and on the instruction of the clockmaker—Edmund Beckett Denison—was struck repeatedly with hammers of increasing size, presumably to get it used to the idea. After a few weeks of this treatment it cracked, so a new bell was cast at Whitechapel. This one succeeded in being hauled into the clock tower, but here the frames were found to be too weak to support its mighty weight. Five months later when new girders had been fitted everything was ready. Then the clock wouldn't start—unable to lift the weight of its heavy hands. Some time later, on May 31st, 1859 to be precise, the chimes of Big Ben were heard for the first time, no doubt startling the patients of Guy's and St. Thomas' as they languished in the dank wards. Two months later the

bell developed a crack and was out of action for three years. Since then, however, it has performed stirling service with only minor interruptions.

Casting our eyes downstream to the unsavoury creeks of Deptford we would have seen, at much the same time as Denison was bashing Big Ben, the launching of Brunel's 20,000 ton steamship "Great Eastern". The "Great Eastern" was a monster which killed its inventor and was a commercial disaster of Concorde-like proportions. *Plus ça change, plus c'est la même chose.* Today we look back on it as an engineering achievement of such scale that it is difficult to praise adequately; certainly not the view of its Victorian shareholders, many of whom it ruined.

Achievement and disaster go hand in hand, but all the evidence suggests that the ratio of achievement to disaster is becoming steadily more favourable as time passes. Those of us who find in the affair of the Tower chimneys evidence of Britain's supposed present malaise should turn again to their history books!

NEWS IN BRIEF

Birthday Honours List

We would like to offer our warmest congratulations to the following Guy's men named in the recent Birthday Honours list. Dr. James A. G. Carmichael, Chief Medical Advisor to the Department of Health and Social Security has been awarded the Companion of the Bath.

Surgeon Cdr. (D) Timothy J. C. Hall, Royal Navy, has been awarded the Order of the British Empire.

The Macdonald Cup

Congratulations to Dr. William Binnie, winner of this year's Macdonald Cup competition in a closely fought match held at Walton Heath.

When Mr. David Macdonald retired from the Consultant Staff of the Dental Hospital in May last year, he presented a silver trophy to be competed for by staff and students annually. Mr. J. Haworth was the first Macdonald Cup champion.

Victoria and Albert Museum

The following two exhibitions will be taking place at the V. & A. in the near future. The first is *Five Centuries of Oxford Printing*, an exhibition of the Oxford University Press and the Spread of Learning 1478–1978. The exhibition begins on the 12th July and lasts through till the 26th September, and can be seen (free) in room 74.

The second exhibition is entitled simply *Cars*—Colour photographs by Langden Clay taken at night on the streets of New York City. The exhibition lasts from July 26th until September 24th, and can be seen in the Exhibition Road Gallery (admission free).

The V. & A. is closed on Fridays.

Alcohol Education Centre

In late September the Alcohol Education Centre is running a course entitled "The Representation of Alcoholism in Cinema and Television" at the National Film Theatre London. A season of appropriate films will be run parallel with the course at the same venue. The course and season have been organised in collaboration with the British Film Institute and the National Film Theatre.

The aim of the course and season is to open the debate on the manner in which alcoholism has been represented in the cinema and on television and to consider the effect that such representations might have on public conceptions of alcohol abuse.

The dates of the course are 25th–29th September and of the season 23rd–30 September. The venue is the National Film Theatre, South Bank, London SE1, and the fees for U.K. citizens are £65.00, and non-U.K. citizens £95 inclusive of coffee, tea, lunch and temporary N.F.T. membership. Application forms are available from:—The Secretary, Representation of Alcoholism Course, Alcohol Education Centre, The Maudsley Hospital, 99 Denmark Hill, London, S.E.5. Telephone: 01–703 8053; 01–703 6333 Ext. 40.

For any further information contact Mike Lewington, course co-ordinator at the above address.

Charles Symonds Ward

Planning for the conversion of the former Caleb Diplock ward to a combined stroke rehabilitation unit is now in hand, and alterations are aimed to start in March, 1979. The work will take about twelve months which means that the first patients could be admitted any time after April, 1980.

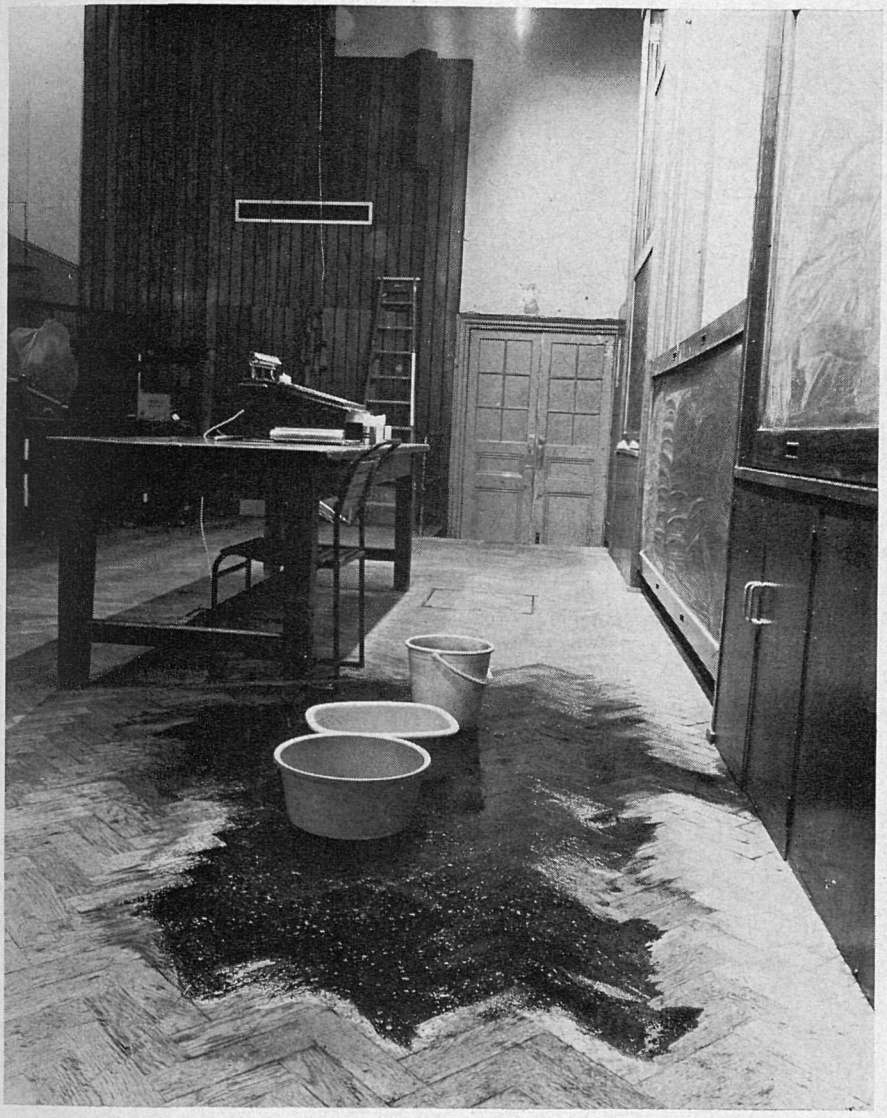
The District Management Team has accepted a recommendation from the Medical Committee Executive that the new unit should be named Charles Symonds Ward.

Sir Charles Symonds, now in his 89th year, was the most distinguished neurologist of his time and the author of the Section on Nervous Diseases in Taylor's Handbook of Medicine, besides being a regular contributor on neurological subjects in all the reputable scientific journals. He retired from Guy's in the mid-1950s when he was appointed Consultant Emeritus Physician for Nervous Diseases.

Ciba Foundation Library

The Ciba Foundation runs a small specialised reference library at 41 Portland Place, London WIN 4BN. It takes 180 periodicals in the biology/medicine/chemistry fields and also has Index Medicus and Science Citation Index. The library has space for up to ten workers but at the moment the facilities are under-used and postgraduate workers are encouraged to use the library.

The library is open from 9 a.m.–9 p.m. every day of the week and may be especially helpful to those who need a quiet place to work in the evenings and at weekends. There is a guide to the library but someone is available to answer any questions from 8.30 a.m.–5 p.m. on weekdays. Photocopying facilities are available.



Hardly a sight befitting the Physiology Lecture Theatre of Guy's Hospital Medical School.

Dates from the Medical Diary

Monday, 26th June—Final Conjoint Examination begins.

Friday, 30th June—Entry forms for Final M.B., B.S. (Old Regulations) Examinations in October must be left in the Medical School Office by this date.

Monday, 3rd July—Basic Medical Sciences Examinations (3rd and 6th terms) begin.

Friday, 7th July—SUMMER TERM ENDS.
Entry forms for the Preliminary Examination for Studies in Medical Subjects (re-sit) must be left in the Medical School Office not later than this date.

Friday, 29th July—Schedules for the Final Conjoint Examination in September must be left in the Medical School Office not later than this date.

Dates from the Dental Diary

Friday, 30th June—Newland-Pedley Medal and Prize for Operative Dentistry —thesis must be handed into the Medical School Office not later than this date.

Monday, 3rd July—Applications for the Final L.D.S. Examination, Part II (Dental Prosthetics) obtainable from the Medical School Office must be left in the Medical School Office not later than this date.

Friday, 7th July—Entry forms for the Preliminary Examinations for Studies in Medical Subjects (re-sit examination) obtainable from the Medical School Office must be left in the Medical School Office not later than this date.

Friday, 7th July—SUMMER TERM ENDS.

Monday, 10th July—Applications for the Final L.D.S. Examination, Parts I and III obtainable from the Medical School Office must be left in the Medical School Office not later than this date.

Advances In Medicine Conference

A conference on "The growing points in Medicine and their interrelation", will be held at The Wembley Conference Centre, London from the 23rd–28th July. It is sponsored by the Royal Society of Medicine. The following subjects will be discussed:—

Diseases of the Breast.
Gastroenterology.
Bone & Joint Diseases.
Endocrindogical.
Cardiovascular & Related Diseases.

With Plenary Sessions:—

Imaging Techniques.
Immunology.
Diseases of Young and Old.
Oncology.
Health Care.

Exclusive to Guy's
10% discount if
you bring this
advertisement along.

made in Heaven

We now have our full summer range of pastel cords, satinised cotton, and velvet jeans (straight leg and flared), 'T' shirts, voile dresses, shoes and accessories.

made in Heaven
18/19, Long Acre,
Covent Garden, London, W.C.2.

also at

made in Heaven
Unit Y4,
Brent Cross Shopping Centre,
Brent Cross, London, N.W.4.

made in Heaven
70, Western Road,
Brighton, Sussex.

Orchard Lisle Swimming Pool

Summer Session

Hours of Opening

Commencing on Monday 5th June, the swimming pool will alter its hours of opening to those usually adopted during the summer months.

From that date the pool will open during the following hours:

MONDAY: 08.00–18.00 hours (Club session 18.30–20.00 hours)

TUESDAY: 08.00–18.00 hours (Club session 18.30–20.00 hours)

WEDNESDAY: 08.00–18.00 hours (Club session 18.30–20.00 hours)

THURSDAY: 08.00–18.00 hours (Club session 18.30–20.00 hours)

FRIDAY: 08.00–20.00 hours

SATURDAY: 08.00–14.30 hours

SUNDAY: CLOSED

Monday to Thursday inclusive, the last ticket will be sold at 18.00 hours and swimmers will be asked to be out of the water by 18.15 hours, so that the club session may commence promptly at 18.30 hours.

On Friday, there will be no club session and the last ticket will be sold at 20.00 hours. Swimmers will be asked to be out of the water by 20.15 hours.

On Saturday, the last ticket will be sold at 14.30 hours and swimmers will be asked to be out of the water by 14.45 hours.

On Sunday the pool is closed.

Any queries regarding this information should be addressed to Mrs. H. D. Hiam, Administrative Assistant, Hotel and Support Services, Extension 2664.

Is Guys Really Crumbling?

Ostensibly this may appear true after the partial collapse of a wall in the 2nd floor X-ray department of the Tower. It seems that one of the 100 one ton concrete rings which goes to make up part of each of the six tower chimneys has disintegrated, causing partial collapse of one incinerator chimney—hence forcing out rubble sideways through the X-ray wall.

However, no need for panic; evacuation plans can be put aside. The works department have erected barriers to prevent any further collapse, and in the unlikely event of this occurring, the surrounding reinforced structural walls would easily withstand this force.

Why did the collapse occur? We will have to await the results of speciments which have been taken away for laboratory analysis. It may even be necessary to completely dismantle the chimneys before any cause can be found.

Meanwhile all surgical waste is being disposed of at New Cross, whilst general rubbish is being taken to a North London tip.

OBITUARY

Robert Tilley, M.R.C.S., L.R.C.P., D.P.H.

Dr. Robert Tilley, formerly in general practice on Hoo Peninsula, Kent, died suddenly on 22nd April, 1978.

Bob Tilley was educated at Rossall School, Lancs., and in his year represented them as a sprint runner at the White City, winning his events in the Public School championships.

He trained at Guy's Hospital, where he qualified in 1941. Whilst a student, he developed an ear infection, before the days of antibiotics, and he maintained that it was only due to the skill and attention of Drs. Molinson and Knott that he survived. He suffered a residual disability of deafness in one ear, which rendered him ineligible for service in the armed forces. He was, however, able to join the Merchant Navy later in 1941 and he served as Medical Officer on the "Rangitiki", which had been commandeered for the duration of the war from the New Zealand Shipping Company. After the war he obtained the D.P.H. at London University and although he acted as Medical Officer in various part-time Public Health appointments, his real love was general practice where he quickly established a reputation as a kindly and competent country practitioner with the art of communication with his patients, which gave them confidence.

He served the rural community for 29 years and is remembered with deep affection by his professional colleagues and many of his patients. His later years in practice were dogged by considerable respiratory disability, but he bore this burden with cheerfulness and fortitude. He spent his last eighteen months in very happy retirement in Dorset. He is survived by his wife, a daughter and three sons, one of whom also qualified at Guy's.

CLUBS' UNION NEWS

A larger bar, a prestigious Union Office, and the Women's Common Room

1. Move the Union office from the lower ground floor to the first floor occupying the Women's Common Room, and overlooking the Consultants' car park.

2. Move the Music Room to the old Club's Union office.

3. Make use of the empty Music Room by installing a dartboard to make it into an extension to the bar.

Over the last three months a survey has been conducted into the necessity of our Women's Common Room. In order to ascertain its popularity a form was sent to each female student requesting her to state how much she used the room on average and whether she would be averse to seeing it used for an unspecified alternative purpose. Of 350 sent out, only 73 replied, 40 stating that they use the room occasionally and were not too happy about seeing it used for something else. There were 33 replies stating that they didn't use it and didn't care.

The interpretation of this result is to rest with the Extraordinary General Meeting which I called for June 20th. The purpose of the Women's

Common Room was, one suspects, to allow women who were not feeling well because of their period to lie down and recover, in addition to escaping the amorous advances of their fellow students. With the provision on Floor 24 of another couch in a room adjoining the "rest room" should they feel this necessary (and remembering that many women now live in Wolfson House) the Women's Common Room has become grossly underused.

It has long been the intention of successive generations of students to enlarge the bar. Once again with Wolfson House the turnover in the bar has increased quite markedly and the provision of additional space has become more important. The music room is the most suitable place—with a dart-board, indirect lighting and comfortable chairs it will add immensely to the bar. Perhaps it will even attract a different sort of drinker.

To move the music room onto the 1st floor is not overly considerate of the residents or the common room users, but to move the Union Office there makes a great deal of sense. It is a bright and spacious room allowing for the possibility of opening a small shop. It would be uncluttered by disco equipment which could be left on the lower ground floor in the music room. In addition with the promise of secretarial help from the Medical School it will provide an attractive workplace for the young girl and a room a great deal more welcoming that at present.

The present Union office would then be redecorated, with the book exchange shelves gone and turned into a versatile music room. With piano placed under the window and special cupboards built for the disco equipment it will make a first class music room suitable for all types of music.

These changes will greatly add to the use of the facilities in the East Wing. They are not to be interpreted as an anti feminist move or, an overt chauvinist takeover, but merely as the "rationalisation of resources". If only 21% of women can be bothered to reply to a questionaire sent directly to them then they surely cannot feel threatened by male domination. Whatever that is.

David Denning.

QUODLIBET SOCIETY

Edward de Bono on "Lateral Thinking"

Tuesday, 6th June, 1978

Lateral thinking is one of those phrases much bandied about these days but few people who use the term actually know what it means. Edward de Bono for many years Director of the Cognitive Research Trust and originator of the expression, came in person to enlighten us. He began by telling a joke . . . A bank manager was very puzzled by one of his latest clients. This was a man who, from his appearance, looked fairly penniless and yet every Friday, without fail, paid in £1,000. Not surprisingly, the manager was extremely happy with this constant flow of money, though at the back of his mind he wondered just where it was coming from. So, the following week he called this chap into his office and congratulated him on his bank balance.

Bank Manager: "But what's the source of your wealth?"

Little Man: "I gamble".

Bank Manager: "Gosh, but how do you manage to keep on winning?"

Little Man: "I only gamble on certainties which I create".

Bank Manager looks both sceptical and incredulous.

Little Man again: "Alright, I bet you £1,000 that by next Friday your nose will have turned to wood".

The Bank Manager, sensing he is on to a good thing, hastily agrees.

One week later the little man returns, accompanied this time by a very jittery friend.

Little Man; "May I inspect your nose please?"

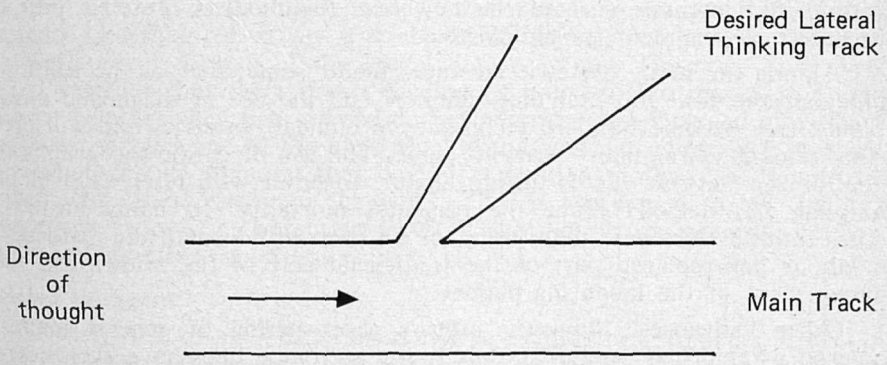
The Bank Manager obligingly thrusts his appendage across the desk whereupon the client deals it a hefty blow and hands him £1,000. Meanwhile, the third party has fallen on the floor in a dead faint.

Victorious Bank Manager: "Well, you made a mess of things this time, didn't you?"

Little Man, smugly: "Not at all my dear fellow". Pointing to friend, "I merely bet him £2,000 I would smash your nose in!"

Humour, it seems, distinguishes us mortals from computers and it is also a feature of lateral thinking. One can look upon thinking as a two step operation, an idea stage followed by a processing stage. The former is essentially a matter of perception, that is, the method by which the brain deals with chunks of information in order to decrease the handling load. There are various types of data processing systems, each with its own characteristics. de Bono chose to consider just two; the discrete system, a feature of machine intelligence, and the pattern system, by which the brain may be considered to function. It is in terms of the latter that de Bono explained the concept of lateral thinking.

The pattern system is characterised by the formation of main tracks of thought, although at any given point in time there can only be one area of attention. Another postulate is that one cannot have two equal tracks, one always dominates the situation.



The problem of how to direct your train of thought off the main track, which most people follow and up the alternative, lateral thinking track, where lie marvellous new theories, fresh ideas, in short the stuff inventions are made of. A variety of mental tricks can be employed in an attempt to achieve this. One can stimulate cerebral movement by deliberately thinking provocative thoughts or try having a second look at things we normally take for granted. Perhaps the most delightful way of solving problems is to pluck a word at random from the air and endeavour to link it to the subject in hand. Hopefully, by this means, one will blunder across the sought-after alternative track and hence to Eureka. Teachers and tadpoles, rabbits and allegation, cigarettes and soap have each been successfully linked together and the background problems answered.

People have been thinking laterally for centuries but it was not until Edward de Bono arrived that we had a working explanation of how the process may occur and the best ways of going about it clarified. Let us hope he has inspired a flood of problem-solving doctors and dentists here in Guy's.

C. M. Haw.

CHILDBIRTH IN A SCIENTIFIC ENVIRONMENT

By N. G. J. Pipe

The practice of obstetrics has long been considered an art. It has until recently lagged behind other medical specialities in the field of research but with increased interest in the area of obstetrics it may now also be considered a science.

Many important advances have been made, particularly concerned with the reduction of perinatal mortality and improving the quality of the life of the newborn. With a decreasing birth-rate, changes in the pattern of confinements are noticeable. Home confinements have almost disappeared and there are few General Practitioners today who are prepared to accept patients for home delivery. It is argued, quite correctly, that with expert medical care available both for the mother during labour, and for resuscitation and intensive care of the newborn, the modern obstetric unit is the safest environment for childbirth.

Among the many obstetric advances made, some, such as the lecithin-sphingomyelin test[1] for fetal lung maturity and the use of diagnostic ultrasound[2] have become standard techniques in clinical obstetrics and will probably remain so for many years to come. The use of cardio-tocographs to monitor the "at-risk" fetus during labour, together with fetel scalp blood sampling has helped reduce the perinatal mortality. In many obstetric units, routine electronic monitoring of all patients, normal and "at-risk", in labour has replaced part of the traditional role of the midwife in the management of the labouring patient.

Other "advances", however, after a short period of general interest undergo a rapid demise. Few people today use or perhaps have even heard of the use of abdominal decompression[3] for improving placental function or the use of vibration[4] to rapidly increase the rate of dilatation of the cervix during labour.

Why therefore, is there an increasing reluctance on the part of many women to accept a hospital confinement? Is it because they are intimidated by the impersonal environment of some of the modern labour suites? Are they perhaps frightened by the flashing lights, alarms and wires of electronic gagetry or feel tied down by catheters and drips. It is worth noting that nobody has yet shown that electronic monitoring in labour is superior to the traditional method by the midwife in patients with *uncomplicated* pregnancies.

Should we not pause and consider the mother also in the process of childbirth, and select patients who will benefit from monitoring during labour, the "at-risk" mother and fetus? The management of uncomplicated labours should still be the prerogative of the midwife and thus restore the close personal contact between midwife and her charge.

References:

1. Gluck, L., Kulovich, M. V., Borer, R. C., Brenner, P. H., Anderson, G. C., and Spellacy, W. N. *American Journal of Obstetrics and Gynecology.* 109 440, 1971.
2. Donald, I. *Year Book of Obstetrics and Gynecology,* 1967-1968. pp. 242-266.
3. Heyns, O. S. *Journal of Obstetrics and Gynaecology of the British Empire.* 66, 220, 1959.
4. Brant, H. A., Lachelin, G. C. L. *Lancet* 2, 686, 1971.

THE WORKING MOTHER

by Tania Phillips

Introduction

The concept of the "ideal family" places the mother in the home and much has been written about the effects of maternal employment upon children. In a recent Ciba symposium (Breast Feeding and the Mother) it was argued by Jelliffe[1] that one of the reasons for the sudden decline in breast feeding during this century has been the changing role of women in society, with increased female employment outside the home.

In view of these ideas, and of the increasing number of working mothers in Britain, a survey was conducted amongst mothers in the post-natal wards of Guys and the Royal Sussex County Hospital. They were asked whether they were breast feeding or not, and the reasons for their choice, whether they had worked during pregnacy and intended going back to work, at what age of the child they would consider going back to work, and whether they thought that having a working mother had any effect, adverse or otherwise, upon the child. Thus it was hoped to test Jelliffe's hypothesis, as well as obtaining views of the mother on maternal employment and its effect upon the child.

Setting the scene

Nearly half of all American mothers of children of 18 years of age, or younger work outside their homes for pay. Society's "ideal family" places the mother in the home; employed mothers violate this concept, as well as the expectations of many other people about the "proper" role of the wife and mother.

Many papers have been published about the effect of maternal employment upon the child. However, in earlier papers prejudices against employed mothers have actually biased the research, because many authors assumed maternal employment *must* be harmful to the child. For example, Hand begins his paper on working mothers and maladjusted children: "The writer has long cherished the opinion that the employment of mothers in occupations outside their homes is a potent factor in producing maladjustment among the children of those mothers."

Many studies of the working mother and her family have been methodologically weak, especially in the use of controls, sample size, methods of data collection and isolation of variables such as poverty, social class and single parent families.

The nearly exclusive assignment of care of the child to the mother is not universally shared by all human societies, Whiting ('72), and Hoffman ('61) could find no constant differences between children of employed and non-employed mothers. In general, it seems that the more careful the methodology of the study, the smaller the differences found.

In a recent paper[3], child neglect was found not to be related to the mother's age, education or employment, but to marital status and family size. Similarly, Simons[4] *et al* found a significantly higher percentage of child abuse in larger families.

Maternal employment in the neonatal period

There is very little literature about the effect of maternal absence at work upon the neonate; only of *continuous* separation of mother and infant. There is only anecdotal evidence from families in which fathers or nursemaids take on a certain part of child care with no apparent ill-effects on the child. However it is generally agreed that the postpartum mother and her newborn baby should be together.

Maternal Employment during Infancy

There seems to be general agreement over the following points in an infant's social development:

1. Infants in varying cultural settings tend to form strong personal bonds with their principal caretakers.
2. Group care (in an infant day centre) does not significantly alter the infant's attachment to its mother.
3. Infants of 11 months upwards can be comforted successfully by a non-mother adult with whom they had had prior pleasant experience.
4. The loosening of attachment to its mother by a ten-month old promotes learning by allowing exploration.

In general, the more recent literature suggests that substitute care during the hours of maternal employment need not be harmful to infants, if given by loving, attentive adults who enjoy taking care of their charges.

Pre-School and School-age children

Pre-school socialisation seems to offer many advantages to children. Children of employed mothers showed no difference in dependancy/independancy, school grades or IQ compared to those of unemployed mothers. (Yudkin[5], Moore[6]).

In general, it seems that if the mother must work, her position in family relationships is likely to be stressed. For the child of course, the major change is the new caretaker, and this should be avoided at times of rapid development, i.e. at 9 months when attachments are forming and at 2 years when symbolic use of language is almost but not quite attained. Children are unlikely to be affected by maternal employment and attendant changes in family functions, if the mother finds satisfaction in work outside the home, and is supported by family members.

Breast Feeding and Maternal employment

Jelliffe[1] considers the changing role of married women, and salaried work outside the home, to be factors responsible for the decline in breast feeding. However Pechévis[7] and Eliot[8] found no difference in breast-feeding habits between working and non-working mothers, and similarly no difference between mothers who worked during pregnancy and those who did not. In view of their findings, this survey included questions on method of feeding the child, the reason for this method, whether the mother had worked while pregnant, and whether she intended to go back to work.

In "Breast Feeding and the Mother" (Ciba Symposium 45) it was stated that "those who advocate breast-feeding may do so from early conviction, probably derived from their mother's". In view of this, mothers were asked whether they themselves were breast-fed or not.

Method

50 mothers at the Royal Sussex County Hospital, Brighton and 25 mothers at Guy's were interviewed in the postnatal wards, and asked the following:

1. What is the occupation of the child's father?
2. Are you breast feeding or bottle feeding?
3. What is your reason for this choice?
4. Were you yourself breast fed or bottle fed?
5. Did you work while you were pregnant?
6. Do you intend to go back to work?
7. If you wanted to or had to go back to work, at what age of the child would you consider doing so?
8. Do you think that having a working mother has any effect upon the child, adverse or otherwise?

Results

Feeding Methods

Guys v. Brighton.

At Brighton, 72% of the mothers interviewed were breast-feeding, 28% were bottle feeding, and of these 10% would have liked to breast feed but could not do so for medical reasons, such as inverted nipples.

At Guy's, 64% of the mothers were breast-feeding. 36% were bottle feeding, and of these, 4% would have liked to have breast fed if possible.

There was no significant difference between the number of mothers breast feeding at Guys and Brighton. Significantly more ($P<.01$) mothers were breast feeding than bottle feeding.

The percentages of mothers breast-feeding in different age groups was as follows:

Age of mother (yrs)	*% Breast feeding*
16–20	63
21–25	45
26–30	82
31–35	87.5
36–40	100

These differences were not significant.

Socioeconomic Group and Feeding method

Significantly more mothers ($P<.01$) in socioeconomic group IV chose to bottle feed their babies, compared with mothers in socioeconomic groups I, II and III.

Socioeconomic Group	*% Bottle Feeding*	
I	29	N.S.
II	7	N.S.
III	26	N.S.
IV	63	$P<.01$

Reasons given for choice of feeding methods

(a) Breast feeding

The following reasons were given for breast-feeding the child.

	%
It is better for the baby	68
It is cheaper	8
It is more convenient	7
It is more enjoyable	5
It is more natural	5
It makes one feel closer to the child	5

(b) The following reasons were given by those bottle feeding

	%
It is more convenient	40
I don't like the idea of breast-feeding	35
Other reasons, e.g. not enough milk, inverted nipples	25

It was found that of the mothers who were breast-feeding, 80.5% were themselves breast-fed as infants.

Of the mothers who were bottle-feeding, 70% were bottle-fed as infants.

Working Mothers

Of the mothers, 60% had worked while pregnant, and of these, 43% wanted to return to work.

Significantly more mothers ($P<.05$) in socioeconomic group I who had worked while pregnant wanted to return to work, compared with socioeconomic group IV.

Age of child at which mother would consider going back to work

Age	*%*
6 months or under	14
2 years	6
3–4 years	32
5 years	38
Over 5 years	10

Opinions about the effect on the child of having a working mother, vs Socioeconomic group.

The majority of mothers interviewed thought that having a working mother would have no ill-effects upon the child, providing that it was well looked after while she was out at work. Many mothers thought that if the child was looked after, for example, in a playgroup, it would benefit by meeting children of its own age, while mother was at work. However 64% of mothers in socioeconomic group IV thought that the child would be adversely affected by maternal employment.

Feeding methods amongst working and non-working mothers

Surprisingly, significantly more ($P<.01$) non-working than working mothers were bottle-feeding their babies.

	Working Mothers %	*Non-working Mothers %*
Breast-feeding	85	64
Bottle-feeding	15	36

Discussion

The decision to breast-feed did not seem to be affected by living in London or Brighton or by maternal age, but socioeconomic group was significant.

Mothers in the higher socioeconomic groups are possibly aware of all the advantages of breast-feeding, and had obtained their information by reading and from advice given in antenatal clinics. This may be an over-simplistic idea, as a bewildering range of factors, physical, psychological and sociological play a part in the decision to breast-feed.

It was interesting that, of the bottle-feeding mothers, almost as many "did not like the idea" of breast-feeding as found it a more convenient method. Attitudes of distaste and embarrassment about breast-feeding appear more frequently in lower social groups. In a recent survey from Newcastle Bacon & Wylie[9] found that more than half the women were prevented from breast-feeding by a sense of shame and that this was tied up with the concept of sexuality related to the breast. In the Newcastle survey, and in other work, an interesting point was the different attitudes between upper and lower social classes to shame, modesty and nudity.

In this survey, 80.5% of the mothers who were breast-feeding were themselves breast-fed as infants. Of the bottle-feeding mothers, 70% were similarly bottle-fed as babies. These results are consistent with Jelliffe's hypothesis that "those who advocate breast feeding may do so from early conviction, probably derived from their mother's!"

In a New York Times department of Labour study (1971), 69% of employed wives said that their main reason for working was to earn money. Of these, 55% said they would continue to work, even if they did not need

the money. In London and Brighton, 64% of the mothers interviewed had worked, while pregnant, and 43% of these wanted to return to work. These mothers were mainly in the higher socioeconomic groups, who did not think that their working would have any effect upon the child. Mothers in socio-economic group II tended not to want to return to work, and were of the opinion that children of employed mothere were at a disadvantage.

These findings were probably related both to job satisfaction, and the quality of substitute care which could be provided during maternal absence. If a mother's employment is rewarding, it seems likely that her relationship with the child will not suffer, and may even be enhanced. Similarly social and economic deprivation that make it necessary for the mother to work when she doesn't want to may be correlated with infant deprivation.

It was interesting that of the 75 mothers interviewed, only one would have liked to go back to work while the child was between 6 months and 2 years old. The literature suggests that the temporarily stressful stage of having a new caretaker should be avoided at points of rapid development, i.e. at 9 months when attachments are forming, and at 2 years when symbolic use of language is almost, but not quite attained (Howell[10]). Perhaps mothers knew this intuitively !

The findings of this study were not consistent with Jelliffe's proposal that bottle-feeding was related to maternal employment. At Guy's and in Brighton, significantly more working mothers were breast-feeding than bottle-feeding. This supports the work of Eliot[8] who found no significant difference in feeding methods between mothers who worked and those who did not.

However the findings in this study could have been due to the fact that more mothers in socioeconomic group I were working, and breast-feeding was more popular in this group anyway, whether the mother worked or not could have been purely coincidental.

References

1. Jelliffe, E. Breast Feeding and the Mother, 1976. Ciba symposium 45.
2. Janeaway, E. Man's world womans place, 1971. New York. W. Morrow & Co. Inc.
3. Oakland. Paediatrics 51, 849, 1973.
4. Simmons. Am. J. Dis. Child III, 600, 1966.
5. Yudkin & Holme. Working Mothers and their Children, Joseph, London, 1963.
6. Moore. Int. J. Soc. Psych 2:1, 1964.
7. Pechéris. Ciba symposium 45, 1976.
8. Eliot et al. Arch Franç Paed: 32, 681, 1975.
9. Bacon and Wylie. BMJ i, 308, 1976.
10 Howell, M. Paediatrics 52, 252, 1973.

After paying you £2,636 a year as a student, the last thing we'll give you is a dull job.

The Royal Navy is looking for a few, a very few, Naval Dental Cadets.

If you have a 2nd BDS (or equivalent), and you can pass our interview board, we will pay you £2,636 a year as a student.

And on qualifying, you'll start a 5-year Short Service Commission as a Dental Officer.

To tell you in advance exactly how you would spend your 5 years is one thing we can't do.

Because we try to keep the system as flexible as possible, to fit in with our needs and your own wishes.

But we can give you an idea of some of the opportunities. You could spend two years in a ship at sea, which is equipped with a surgery with all the equipment that you'd find on shore.

Or you could spend a series of short periods moving from one ship to another.

In that case, you might well expect to be winched from ship to ship by helicopter.

And you'd have with you a complete, portable dental surgery.

Part of your time, you'll certainly spend on shore. (In fact, one of our Dental Officers has chosen to spend the whole 5 years on shore.)

So you might have a couple of years at a Naval establishment, which could be a training establishment, where you'll be treating young sailors. Or a NATO base, where you'll be looking after anyone from ratings to admirals. We also have a flying squad, all volunteers, mostly young and unmarried.

They're ready to down drills at any moment and take off for a spell at a different Naval shore base or in a ship wherever she may be.

The principle is that we take dentistry to the patient. You don't have to wait for him to come to you.

And, basically, your job is to see that the Royal Navy's sailors and officers are fit enough to do their job. Given that, you'll have the same clinical freedom, the same equipment and the same materials as you'd find on shore.

The dentistry, however, is only part of the job.

You'll also be a Naval Officer.

When you're at sea, you'll be part of the team of Officers who are responsible for running every aspect of the ship.

You'll be able to enjoy the sports and social facilities which the Royal Navy offers.

Which leaves the question of pay.

Immediately after you qualify, your salary will be £6,517.

And at the end of your 5-year Commission, you'll leave with a gratuity.

Or you can apply for a Full Career Commission or a 16-year pensionable Commission.

If you'd like to know more, write giving details of your age and qualifications to: **Surgeon Captain (D) F.R.B. Mathias, RN, (26GS), Room 314, Empress State Building, Fulham, London SW6 1TR.**

NOTICE

Subscription Increases

It is a hard time for small businesses and enterprise in general and the *Gazette* is no exception. Unfortunately, much as we regret it, we are no longer able to contain the rises in our overheads, continuous since October, 1975, without an increase in subscription.

To keep the increase to a minimum the *Gazette* Committee has proposed that there should be no August issue and that the November and December issues should be combined into a bumper Christmas edition this year. This of course means a certain loss of continuity but the November and December issues have always been head to tail and the "bush telegraph" is never too active at the height of summer anyway!

We hope that our subscribers will continue to support us for the future, for only with your support can we continue to inform and entertain the Guy's community.

The new rates are: Full subscription £6; Newly qualified £3.

WOMEN AND DRUGS

By Sue Barlow
Department of Pharmacology

Introduction

A nationwide survey carried out in 1969 by the Institute for Social Studies in Medical Care, directed by Ann Cartwright, showed that women were larger consumers of medicines than men. In a two-week survey period, covering almost 2,000 adults, amongst the women, 50% had taken a prescribed drug and 75% an over-the-counter remedy, compared with only 30% and 60% respectively amongst the men. It also showed that twice as many women as men had taken drugs for anxiety, depression or sleeping problems, a fact which was vigorously reflected (or reinforced?) in drug company advertising of the early 1970's, such as that depicting the tired, harassed housewife with too many kids and poor housing, for whom an antidepressant was the proferred solution.

The Cartwright study also showed a woeful lack of information about drugs acting on the central nervous system amongst takers. So in the ensuing ten years, has anything changed? With the exception of barbiturates, prescriptions for tranquillisers, hypnotics and antidepressants have been steadily increasing. So are women taking even more of these drugs than before, a situation which few would be complacent about? To take a look at some of these problems, in January this year, one of Britain's largest women's weeklies, *Woman's Own*, launched a survey on drugs amongst its readership. What kinds of drugs were they taking? What did they know about their drugs? Where did they get their information from? What about side effects? In all, 32 different questions were asked. Almost 3,000 women replied; not as many as in the magazine's earlier sex survey, but at least it is a healthy sign that the public are more interested in sex than in drugs! Nearly 1,000 wrote letters as well, in many cases expressing substantial reservations about the drugs they were taking and their G.P.'s prescribing habits, together with a sprinkling of genuine horror stories that such a survey is bound to elicit.

Who replied?

Of the 2,790 replies analysed, the typical respondent was likely to be middle class, married with two children. Compared with the adult female population in general, working men and women in Social Classes I and II were substantially over-represented in the sample, and younger married women slightly over-represented. Clearly, it would be risky to apply the findings of this survey to drug-taking amongst women as a whole, but amongst this self-selected group of higher-than-average drug consumers, a number of important findings emerged, in particular what patients want to know from their doctors about the drugs they are given.

What drugs were they taking?

A high proportion of women were taking drugs for anxiety, depression or sleeping problems (see Table 1), confirming the studies of ten years ago. 94% of respondents were taking prescribed drugs of any sort at the time of filling in the questionnaire. 13% of these were taking oral contraceptives only, leaving 81% on other prescribed medicines. These figures suggest that women on drugs were more likely to fill in the questionnaire than those not on drugs. Only 12% reported taking medicines bought over the counter despite a specific question eliciting this information. It is almost certainly an under-estimate, illustrating once again how few people regard such remedies as "real drugs", though many have powerful pharmacological effects and side effects. Of those taking self-prescribed or prescribed medicines, one-third were taking only one drug, one-third two drugs and one-third three or more drugs. Two-thirds reported taking their drugs for years rather than months or weeks, a finding which is not surprising in view of the types of drugs being taken such as tranquillisers and oral contraceptives.

Comparing with national statistics, women in the survey were two times more likely to be taking sedatives or tranquillisers, two times more likely to be taking sleeping tablets and five times more likely to be taking anti-depressants* than the average member of the population, their overall consumption of drugs in these categories being 2.5 times the national average. Other notable deviations from national figures were in the consumption of

TABLE 1

Reason for taking prescribed drugs	*% of respondents taking drugs*
Depression	19.1
Nerves / tension / anxiety	26.5
Headache / Migraine	12.4
Colds / flu / coughs	3.5
Sleeping	14.7
Slimming	2.8
Menopausal disorders	5.6
Pregnancy problems	2.7
Period problems	5.8
Contraception	28.8
Any other disorder / illness	40.5

**This category may be slightly inflated by drugs prescribed for depression which are not specific antidepressants.*

prescribed drugs for headache and migraine (perhaps reflecting the known higher incidence of these symptoms in women than in men), and in drugs for slimming which, at a conservative estimate, was almost three times higher than the national average.

Women are known to take drugs more frequently for the same reported symptom than men. In addition, they tend to report more symptoms. What is not clear is whether doctors prescribe drugs more freely for women patients in response to demand, or whether doctors' assessments of need for a drug is biased by the sex of the patient. It is a widely held belief that the latter is true, particularly when it comes to prescribing psychoactive drugs. This notion, however, has been challenged in recent studies showing that sex is only one (small) component of the medical, social and environmental factors influencing the decision to prescribe.

Knowledge about drugs

Almost all (98%) of the respondents said they knew the names of their drugs. But only 70% got this information from their doctor and one-third of these had to actually solicit this information from their doctors. Similarly, the overwhelming majority on drugs (99.5%) knew when to take them, and here doctors were a little better at informing patients; 81% got the information from their doctors, 8% from pharmacists and 27% from the label on the medication alone or in addition to information from doctors or pharmacists. In view of the high incidence of so-called patient "non-compliance" in drug taking, it would seem that this is not due to patients' ignorance of the dosing schedule. Clearly other factors such as memory, convenience and motivation are intervening to influence drug taking.

The majority of respondents knew whether they were on new drugs (13%) or well-established drugs (57%). 30% replied that they did not know. Here doctors were very poor at informing patients; only 28% had this information volunteered by their doctors, 8% had to ask their doctors, and 31% only had this information because they had read or heard about it elsewhere.

Side effects

It was on the subject of information about side effects that doctors came in for most criticism. The true incidence of side effects is very difficult to ascertain and figures may be selected from other studies to support either the "killer pills" lobby or the "relatively safe" lobby. In the *Woman's Own* survey, side effects were reported by 50% of the drug takers, and of these, half were rated as "mild", one-quarter as "not very serious" and the remaining quarter as "fairly serious". Of those reporting "fairly serious" side effects, 80% were taking two or more drugs, with oral contraceptives, major and minor tranquillisers, and drugs for treating rheumatism featuring prominently in this category.

Those on new drugs were more likely to report side effects than those on well-established drugs, which contrasts with the medically recorded incidence of side effects where older drugs take the bigger toll. Perhaps patients are more on the lookout for side effects if they know they are on a fairly new drug, one of the few saving graces for our much-criticised voluntary reporting system for side effects of drugs.

72% of those reporting side effects continued to take the drugs that were causing them but 60% had to refer back to their doctor for help in dealing with them, suggesting that this is a problem which may well occupy a fair proportion of a G.P.'s time. It also suggests that the enormous under-reporting of side effects to the Committee on Safety of Medicines (who estimate at best 10% are reported to them on yellow cards) is not due to failure on the part of the patient to bring side effects to the attention of doctors but rather that doctors do not have the time or inclination to pass that information on. Hopefully, the proposed "monitored release" scheme for new drugs may improve the situation in the future. Not only do doctors not pass information on to the C.S.M., some do not even note side effects on patients' records; one woman in the survey twice experienced the same intolerable side effect from a drug and told her doctor on each occasion, but some months later the doctor offered her the same drug again.

Doctors and side effects

When it comes to informing patients about side effects, there is a major conflict between doctors and patients; most patients want to know about possible side effects beforehand, but most doctors are wary of giving too much information for fear of worrying patients unnecessarily or on the grounds that patients are more likely to get side effects if warned about them. In the present survey, under half (47%) of those reporting side effects were warned about them beforehand and of those not warned, 98% thought they should have been.

One of the most worrying features to emerge from the survey was that doctors are far less likely to warn patients about serious side effects than about mild ones (see Table 2). G.P.s are notoriously ill-informed about

TABLE 2

Side effects reported	*% of drug takers*	*% in category warned*
None	50	—
Mild	25	52
Not very serious	13	43
Fairly serious	12	22

side effects and drug interactions and this was reflected in the information patients got. 63% of the women reported that their doctor never asked them if they were taking any over-the-counter medicines before writing out a prescription, 12% sometimes asked and only 20% consistently asked. The survey did not specifically ask whether women were warned about driving, drinking alcohol and eating particular foods when on certain types of drugs, but a number of the letters received mentioned dangerous side effects they had experienced because they were not warned, or were warned incorrectly about these things. Clearly, this is a major problem area in medical education, since it is important that doctors are aware and patients warned of possible serious side effects which can cause lasting debility if medication is not stopped as soon as they appear. Perhaps if patients were warned about serious side effects it might well cause considerable worry to a few, but might help instil a more realistic attitude about the risks and benefits of drug taking in the population as a whole.

Pregnancy worries

Prescribing drugs during pregnancy requires particular care and the women surveyed were obviously aware of this. 39% of respondents were "very worried" about taking drugs during pregnancy, 28% "slightly worried" and only 13% "fairly happy" or "happy", (20% did not reply). Following the thalidomide disaster, both medical and lay awareness of the problem has increased but with little significant impact on drug consumption during pregnancy. Since that time, drug taking in pregnancy has, if anything, marginally increased both in terms of the proportion of pregnant women taking drugs and in the average number of drugs taken by each woman.

Coming back for more

47% of respondents said their doctor gave them a prescription at every visit and 62% could get repeat prescriptions without seeing their doctor, a practice which is frequently condemned by the profession yet regularly done. Nationally, 45% of all prescriptions issued are repeats with no doctor-patient contact. A number of women wrote that even after changing to a new doctor they still got prescriptions without ever seeing them. Typical of bad practice in this area was one woman who got a prescription for Betnovate, a steroid-containing skin ointment which should be used with great caution, from her new doctor, unseen, having been prescribed it two years earlier by another doctor.

What do patients want to know?

Overall, only 46% of respondents said they were satisfied and the remainder were dissatisfied with the information given them by their doctor about their drugs. Table 3 shows the type of information not given to the dissatisfied group in comparison to the satisfied group. The widespread reluctance of doctors to give patients information can hardly be supported in view of studies showing that simple but full explanations of the drug in general and the nature of the illness does improve patient compliance in drug taking.

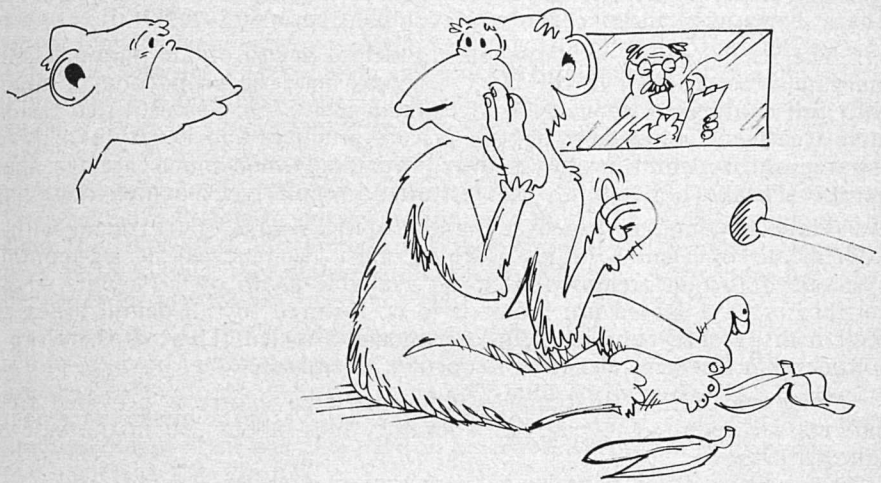
TABLE 3

Information given by doctors		*Information not given about drug*		
	% of respondents	*Name*	*Mode of action*	*Side effects*
Sufficient	49	41	65	79
Insufficient	46	10	12	31
No reply	5	—	—	—

Conclusion

In conclusion, whilst the nature of this survey does not permit firm generalisations, it does suggest that women are getting the bulk of the psychoactive drugs, about which there is much criticism on overprescribing. The survey also showed that G.P.s are failing to give women the information they want about the drugs they take, a situation which in some instances might seriously endanger the health and life of the patient.

A spokesman for the B.M.A., when asked for comment, questioned the validity of the survey and suggested that replies were "likely to be from people who are interested in the question and who may have an axe to grind". Surely it is these very patients we should be listening to if we are to improve doctor-patient relationships and educate the public about the risks and benefits of drug taking?



" That scientist out there must be a sucker 'cos every time I pull the lever he gives me a banana ! "

OPPORTUNITIES FOR DENTAL PRACTICE IN THE NETHERLANDS

A Report by the Association of Medway Dentists

Dutch citizens earning less than 33,000 guilders per annum (about £7,680) pay a compulsory contribution to a Sick Fund Society. This amounts to 4.1% of their earnings, and their employer contributes an equal amount. The self-employed pay the full 8.2% themselves.

Contributors are entitled to medical, dental and surgical treatment free at source, and assistance with hospital stay, nursing and medication expenses. Other people must either pay privately or make arrangements with a few insurance companies which operate a scheme. There are special provisions for the treatment of children, handicapped and unemployed patients.

There are about ninety Sick Fund Societies in Holland. There are a few clinics in the larger towns, but contributors are mostly treated in mixed practices by general practitioners. Amsterdam is a special case, where S.F.S. contributors are treated in clinics alone, provided by a consortium of four societies. These are known as the A.T.Z. Clinics and are twenty-four in number.

Approximately 70% of the population is covered by the S.F.S. scheme and the special provisions. The remaining 30% may only receive private treatment. Nevertheless, many S.F.S. contributors elect for private treatment either through choice or because the range of treatment available in the service is restricted to fillings, root-fillings, acrylic dentures, prophylaxis (by dental hygienists) and orthodontic therapy by removable appliances. There seems to be little accent on preventive treatment.

The result is that on the whole the dental health of the nation is only marginally better than in the U.K. Whereas here the proportion of adults with full dentures is about 34% in Holland it is 27%. Sophisticated restorative treatment is available only in private practices and is very expensive. Awareness of dental health is also surprisingly not much greater than here—only 40% of the S.F.S. patients attend regularly for dental treatment.

These patients are issued at the end of the course of treatment with a "*Certificate of Dental Fitness*" *which must be renewed at six-monthly* intervals if further treatment is to be available at no cost. Patients whose certificates have lapsed are required to be restored to full dental fitness at their own expense before another certificate is issued. There is therefore a considerable financial incentive to regular attendance.

Whereas routine treatment of this restricted nature is provided free, patients are required to pay the laboratory bills, about £50 in the case of full dentures.

Delivery of treatment

Patients attend the S.F. Clinics for examination for one hour each morning and afternoon, and the dentist must be available to provide this service.

There is a two-part out-of-hours emergency service provided at selected points, for which patients have to pay extra fees. Dentists may take part either on the basis of five nights a week cover or week-ends only, in which case they stay in accommodation provided at the clinic. It is understood that the remuneration for this service is very high.

The school dental service is provided by dentists who work either entirely within the service, or by some involved in both school and clinic service. Six-monthly inspections are carried out in mobile units visiting the schools, and patients are treated in them or referred to the nearest clinic. Certificates of dental fitness are issued to children on leaving school, which entitle them to a rather wider range of treatment (e.g. crowns) than is available to adults, until the age of eighteen.

All general anaesthetics and sedation techniques are regarded as in-patient procedures. Orthodontic treatment by fixed appliances and oral surgery (except minor oral surgery in the remoter areas) is referred to specialists.

Qualitative control is provided in the S.F.S. system by a team of inspectors appointed by a board consisting of representatives of the S.F. Societies and the Dutch Dental Association. Prior approval is required for some forms of treatment, e.g. orthodontics.

The role of the Government and the Dutch Dental Association

In Holland there is no equivalent to the General Dental Council, so the D.D.A. assumes many of their roles in respect of negotiations and internal discipline. The government is involved to a very limited extent, only in a licensing and advisory capacity through the Dept. of Public Health. This Department is enabled to issue both "Full" and "Restricted" licences (Categories A & B respectively). A full licence is required to enter private practice and is at present issued only to holders of the Dutch Dental Diploma who are either Dutch citizens or foreigners who qualified before 1967, other foreigners being issued only with the restricted licence which enables them to practice only in the S.F.S. Clinics.

The D.D.A. appears to be in a very strong position, with a powerful parliamentary lobby. A few years ago they initiated legislation whereby foreigners are unable to pursue training for the Dutch Dental Diploma, and since the Dept. of Public Health may issue Category A licences to foreigners only if they hold this diploma, effectively therefore foreigners have been barred from private practice since 1967.

Training for the specialities (oral surgery and orthodontics) consists of a four year postgraduate course, and qualification is by certification as there are no examinations. In order to comply with forthcoming E.E.C. requirements an examination system will have to be introduced, and the undergraduate curriculum will also need to be reduced from six to five years.

The D.D.A.'s attitude to foreigners is coloured by their worries about what they consider is the over-protection of graduates from their dental schools. There are five such schools in Holland, qualifying about 400 graduates a year, and the Dutch population figure is now stable at about 13½ millions. As a result the patient:dentist ratio has dropped below 3,000:1 this year for the first time, and the downward trend continues. Corrected for patient demand by removing the full denture wearers and infant population this figure is nearer to 1,600:1 and for this reason it may be inferred that the D.D.A. may be less than wholehearted in its co-operation in negotiations for free exchange. They are taking a firm stand over equality of diplomas and the need for immigrant dentists to be familiar with the Dutch language. Also, whilst outwardly co-operating in the training scheme for "New Cross-style" auxiliaries, they are unlikely to sanction their general introduction into practice.

Conclusions

1. **Opportunities.** Free exchange within the E.E.C. is likely to be delayed for at least three years, and the D.D.A. are frankly less than enthusiastic. At present therefore the only opportunity for the foreign dentist to practice in Holland is in a Sick Fund Clinic on a Category B licence. These licences are only issued for an area where unfilled vacancies exist.

2. **Earnings Potential.** Dentists who work in the S.F. clinics are paid on a fee-per-item basis, and these fees are, on average, 50–100% higher than in the National Health Service. 40% of the dentist's gross income is deducted at source to cover expenses, but this proportion decreases after a certain gross has been achieved. A dentist in the U.K. capable of an "average" N.H.S. income of say £8,000 per annum would need to gross (assuming an expense ratio of 56%) about £18,000 per annum. Such a volume of work in the S.F. system would produce, on the basis of the figures mentioned earlier, a nett income (before tax) of approximately £16,000 to £22,000. Those capable of a higher output can of course calculate the amount they could anticipate in proportion to their ability to exceed this target. The overall income tax commitment in Holland is lower than in the U.K., to the extent that for the equivalent turnover one could expect a nett income after tax of about three times that of full-time N.H.S. practice.

3. **Costs.** In the S.F. system there are no costs over and above the 40% deduction at source for expenses. Since the overwhelming majority of practices are single handed, no opportunity for foreigners to practice in the S.F. system outside the clinics effectively exists, i.e. as locums or assistants, and therefore the cost of setting up in practice need not yet concern us. As a matter of interest however, it is understood that finance from banks and insurance companies is freely available to dentists, indeed it is common for the newly qualified to borrow up to £250,000 in order to purchase a house and set up in practice!

   In Amsterdam persons on low incomes (certainly not dentists!) can obtain relatively cheap subsidised rented accommodation. Otherwise, a substantial flat in the central area would attract a rent of £200 or more a week, but more modest rooms can be obtained in the suburbs for considerably less. The purchase of a house however is likely to cost at least £100,000 in the big city centres.

   Since only full-time employment is allowed under a three year contract (after an initial three month trial period) commuting to Holland is not a practical proposition. It is as well to remember also that if more than 62 days per year were to be spent in the U.K. one would perhaps become liable for income tax in this country as well.

4. **Procedure.** A foreign dentist wishing to work in Holland should write in the first instance to Herr Blokke, A.T.Z., Cornelis Dirkszstraat 29, Amsterdam W. Request details of vacancies, and application forms. When these are completed and returned they will be sent on to the Dept. of Public Health which will arrange for your qualifications to be vetted, and if this is satisfactory a Category B licence will be issued.

NOTICE

A meeting of the Pupils' Physical Society will be held in the Gordon Museum Lecture Theatre at 1.00 p.m. on Monday, 26th June. Three papers will be presented by Lloyd Denmark, John Masters and Richard Walkey, and Jon Beard. All welcome. The meeting will last one hour.

CASE REPORTS

Tuberculosis in the Community

by Dr. R. M. Turner

Since mid-1974, 12 patients from the population served by the Lakeside Health Centre at Thamesmead (totalling about 9,500 people) have been found to have tuberculosis (Table 1).

Case No.	Age	Sex	Racial Origin	Site of Infection	Symptoms
1	64	M	British	Lung	Productive cough, loss of weight
2	37	M	British	Lung	Cough, fever, pleural effusion
3	27	F	Irish	Kidney and bladder	Recurrent loin pain and fever
4	21	F	West Indian	Miliary	Chest pain, fever, haemoptysis
5	37	M	Pakistani	Pleural effusion	Fever, cough
6	47	M	British	Lung	None (found on X-ray)
7	17	M	Kenyan Asian	Lung	Fever, haemoptysis
8	12	M	Kenyan Asian	Lung	Erythema nodosum
9	10	M	Kenyan Asian	Pleural effusion	Fever
10	49	F	Kenyan Asian	Pleural effusion	Productive cough, loss of weight
11	24	F	Indian	Mediastinal lymph nodes	Backache, joint pains
12	67	M	British	Lung	Exacerbation of chronic bronchitis

Cases 7, 8, 9 and 10 were all members of the same family.
Three patients (cases 1, 6 and 12) had a positive sputum.

Discussion

There are still about 10,000 notifications of tuberculosis in Britain each year, and about 1,000 deaths from the disease. Vagrants and undernourished alcoholics are vulnerable, and the rate is also high among immigrants. Between 1965 and 1971 annual notifications fell by 43% in the native-born population but rose by 68% among immigrants (Tubercle 1973), the same report quoting a rate of infection 11 times higher in Pakistani immigrants than among native British. No-respiratory infection occurs in 30% of immigrant patients and only 10% of British patients (Springett 1972). A recent survey from the Potteries showed that the Asian 2% of the population contributed 25% of the notifications of tuberculosis (Prowse and Cavenagh 1976).

Diagnosis of tuberculosis may be difficult and the clinical picture confusing, as in case 11. A housewife aged 24 with a past history of anxiety became very depressed after her first baby was born. Two weeks after delivery she complained of backache for which no cause could be found. Four weeks later she had more backache and was found to have an E.S.R. of 55 mm in one hour. The E.S.R remained high and within three weeks she had developed widespread joint pains and loss of extension of her right elbow. She was referred to a rheumatologist (there was a family history of rheumatoid arthritis) but nothing was found, and she was then seen by a general physician. Five months after her first symptom some enlargement of paratracheal and mediastinal lymph nodes was detected on X-ray, and she also had a strongly positive tuberculin test. Antituberculosis treatment resulted in rapid improvement.

One patient (case 12) has died. He was a man aged 67 with a long history of chronic bronchitis, in whose sputum tubercle bacilli were found during an exacerbation. He died from his bronchitis four months later.

It is interesting to reflect how the dread of tuberculosis infection has diminished as it has become less common and more responsive to treatment. The joy of one man (case 1) who believed he had lung cancer was quite remarkable when told that he had "only" pulmonary tuberculosis. Equally memorable was the lugubrious demeanour of another man (case 6), attending for routine prescription after the diagnosis had been made. Invited to explain his gloom he said, aggrievedly, "Well, when you got T.B. in the old days you were sent away to hospital for a rest. Now they just give you a handful of tablets and tell you to go back to work!"

This small series of cases in Thamesmead is a reminder that tuberculosis is likely to occur sporadically for many years to come.

References

British Thoracic and Tuberculosis Association: Report of Research Committee, Tubercle, London 1973, 54, 29.
Prowse, K. and Cavenagh, P. Lancet 1976, 2, 357.
Springett, V. H. British Medical Journal 1972. 1, 422.

Acute Confusional States: Three Cases from General Practice

Acute confusional states may arise from a variety of physical causes as well as during the course of psychiatric illness. The most familiar physical causes are fever (giving rise to delirium) and drugs, notably alcohol.

Three cases illustrating organic disease presenting as acute confusion are described. All were seen in general practice at Thamesmead.

Case 1

Mr. A. W., a car assembly line worker aged 50, was visited at his home at 4 a.m. in response to a call from his wife. He was wandering restlessly round their flat dressed in pyjamas, socks, cap and raincoat, saying he was looking for his sandwiches to take to work. It was impossible to persuade him to sit down or to answer questions. There was no history of psychiatric illness, but his wife felt that he had slowed up over the previous 18 months and had become forgetful and absent-minded.

Investigation in hospital revealed a low serum sodium, and serial chest X rays eventually disclosed an enlarging hilar mass which proved to be an

oat-cell bronchiogenic carcinoma secreting antidiuretic hormone. The condition was inoperable, but correction of the hyponatraemia quickly abolished his confusion. He died at home a year later without any recurrence of confusion.

Case 2

Mr. H. H., a building site foreman aged 64, was seen at home at his wife's request. He was seated on his bed in a state of profound apathy. His speech and movements were slow, his expression puzzled and worried. He was unable to give a history and examination showed no obvious cause for his condition.

His wife said that he had been unwell since he had been made redundant at work six months earlier. He had become depressed and withdrawn, had lost his appetite and complained of vague pains. There was no past history of psychiatric illness, and his condition had not improved on antidepressants.

He was admitted to hospital where investigation revealed a bronchogenic carcinoma with a frontal lobe metastasis.

Case 3

Mr. M. D., aged 52, had been unemployed for ten years, when he moved to sheltered accommodation in Thamesmead in February 1976. He had a long history of psychiatric illness. Treatment, including ECT as an in-patient in 1948 and 1964, had been ineffective, and psychiatrists who had treated him agreed that he had a severe personality disorder with depression. He had multiple complaints of pain, weakness, anxiety and depression, but examination revealed moderate hypertension only.

In January 1977 he had two major epileptic fits while watching television. He presented himself at a mental hospital, was admitted overnight and subsequently seen in outpatients before being discharged as a personality disorder. He moved away to another area where his epilepsy was investigated, EEG and skull X ray being normal.

In October 1977 he returned to Thamesmead. He was confused and uncomprehending, repeating words and questions in a slow monotone and incapable of rational reply. He said he could not use his right hand though was observed to be doing so at times. It was only with difficulty that he could be persuaded to wash, dress or eat. He was readmitted to a mental hospital but was discharged later as not needing inpatient care. When seen at home again his condition was worse, he was barely able to walk and had possible weakness of his right leg and apparent total inability to use his right arm, although this had been regarded throughout as hysterical. Admission to a general hospital led to eventual discovery on brain scan of a parietal lobe tumour.

Discussion

These cases illustrate some of the problems of diagnosis of confusional states in general practice. Two of the three patients had no history of psychiatric illness. Case 1 was not seen until a crisis arose; the second patient had quite reasonably been regarded as depressed after losing his job; and in the third case a man with a lifetime of mental illness developed epilepsy and was twice discharged from mental hospitals before the diagnosis was made.

FILMS AND THEATRE

One can get the feeling when looking through daily papers that you have seen the same names for years. **Close Encounters, Star Wars, Annie Hall, Looking for Mr. Goodbar,** etc., seem to have been around for years. New films do arrive, some with a crash, some with a whimper.

A film that has arrived recently with most favourable reviews is **The Shout**. Starring Alan Bates and Susannah York, this is a tale of a man, one national daily said he portrays a madman, others have said he is sane —you have to make up your own mind, who is able to use his voice to shout and kill. The whole tale is told during a cricket match between the doctors and patients of a lunatic asylum, which allows for certain comic moments between the dramatic events related. It is filmed in a most interesting fashion and shows how this man (Alan Bates) uses the power of his voice to take another man's wife (Susannah York). It is an excellent film which recently won the Jury Prize at the Cannes Film Festival.

There is now a spate of films showing how the boys from "Nam" are coping with life back home. One of these which has been much reviewed is **Heroes** starring Henry Winkler (the Fonz). Actually he plays the part very well but the story is rather old. War veteran travelling across the U.S.A. to find his old buddies meets girl on bus. They travel together, find one, not another and discover that the last was killed in the war saving our hero (H.W.) which he had blotted out from his memory. He goes wild briefly, cries, feels better and he and his girl live happily ever after. There are some amusing scenes but on the whole—hmm.

A better film is **Tracks,** seen in Britain last year but almost certain to return. It has Denis Hopper taking his dead buddy home to be buried or at least that's what you think, but the film has some incredible moments and the biggest twist at the end imaginable. An excellent film.

The Duellists, recently in the West End, now doing the rounds elsewhere, is a film worth seeing purely for the photography and lighting. I believe it is a British film, but it has two American actors playing Napoleonic French officers. The accents grate a bit at first but after a while one does not notice it. The story tells how these two officers duelled all the way through their military careers. This gets a little tiresome eventually but is worth seeing because it is so beautifully filmed.

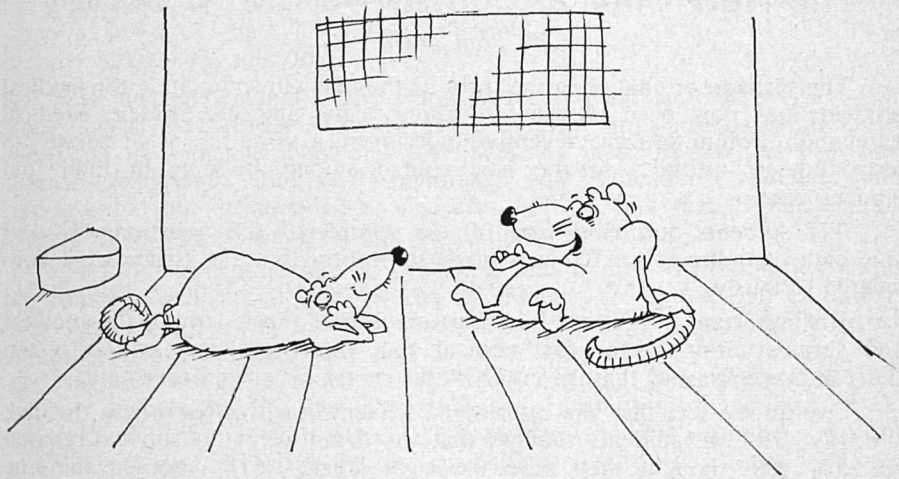
As a brief addition to my previous article, on cinemas, I would like to include the Academy complex in Oxford Street (min. price £1.40) which at the moment is showing Bunuel's new film **That Obscure Object of Desire,** a masterpiece by an excellent director. I recommend it to everybody. It shows a man trying very hard, by every trick and treat, to get a beautiful young girl to go to bed with him. It is totally non-pornographic and one of the funniest films to be seen at the moment. Bunuel is a master of surrealist films, of which this is an excellent example.

Finally, the Everyman in Hampstead which shows nothing but golden oldies. It often has seasons of Bogart, horror films, science fiction movies, old musicals, etc. It is quite cheap and well worth looking out for.

Bob Peck.

Michael Dixon adds :

Readers will know by now that this is not a column that would hide anything from them. Indeed, we sneer at those other writers in the *Gazette,* or elsewhere in the national media, whose only concern is to plaster up those seedy little cracks, and to provide us with a view of humanity which is just eyewash. That is to say that in this column there is no bluff, no long winded apology for the world being the way it is. And if for instance, the writer of the column had not been to one single film or one single theatrical production in the last month; we would tell you, with the confidence that our cultured readers would thereby consider the writer to be an honest man, rather than an incompetent idiot, who should never have been writing about films and theatre in the first place.



" It's all part of life mate, you take the pellets with the shocks ! "

Well sadly that is the case, and the hot summer is to blame. In hot summers people either go outside or work inside, and no one goes out to films or theatre except the American tourists, who have booked out the theatres anyway. Most of us are having to work inside rather more than we want with examinations in the offing. So, as you will have guessed, I will not be discussing either films or theatre this month as nobody else will be able to see any either (in fact with two redundant paragraphs already finished I probably won't have to discuss anything at all).

Instead, I dedicate this article to those taking or about to take examinations. It's an approach which is as new to examinations as lateral thinking was to thinking, and is highly recommended for those whose blood pressure is already 110, who can't stand the sight of blood, or whose fathers pushed them into medicine. . . .

So . . . you mosey into that ol' hole of an exam room and you finds yourself a patch, and you throws down your ink and pens and that.

Then . . . you takes your time, you settles down, real easy man, real cool. You strums a few lines of "swanny river" and cracks open a bottle of bourbon and drink deep—real deep—"Say—this is the biggest macrobiotic trip ever—narcotics nothing!" Now just you lean back, man, real easy, and pull your hat far down over your eyes like as how NOTHING and NOBODY is going to trouble you NO WAY (From this position you should be at a good vantage point vis-a-vis the exam paper).

Yeh, right on. So . . . Yeh. Look don't worry man. I mean. . . . Like these examination freaks. I mean its a bad trip. You don't want nothing to do with it. Just don't let them bug you that's all. Like they've got it all wrong, man. I mean work, work . . . you know what I mean. Yeah.

. . . Oh man. Oh boy. . . . Anyone seen a doctor. . . .

The New Clinical Course—a SMEC Survey

By Paul O'Hare

The tornado of change in the form of the new clinical course for medical students has now been blowing for three years, and the Student Medical Education Committee has recently undertaken a comprehensive survey to test students' attitudes to the new course among students in their 2nd clinical year.

111 students out of a year of 128 completed the questionnaire and this high compliance we felt was good indication that the issues were considered seriously.

An important suggestion has been made that the length of the medical and surgical firms in the first clinical year under the new course is too short at 8 weeks, and that 10 or 12 weeks might be an improvement.

Overall we feel that the attitude of students on this issue was divided. "Ideally" 75% of students thought that the firms were too short compared to 25% who thought they were the right length. 61% thought that the ideal length was 10 weeks. But to the suggestion that the 1st year elective short at 8 weeks and that a return to a longer firm of 10 or 12 weeks should be reduced from six weeks to four in order to achieve longer firms, 83% replied that this was not desirable. On the issue of a reduction in the pathology block course during the 1st clinical year in order to increase the length of the medical and surgical firms, while 58% considered this desirable a large minority of 38% think this undesirable. The suggestion that the whole of the third year be spent as an "active shadow" met with a poor backing of 86% rejecting the idea. We felt that this was because the period in question is immediately before finals. A shorter period of 4 weeks as an active shadow was backed with 78% agreeing and 58% agreeing even if the final two firms were reduced to 6 weeks each.

As a committee, therefore, we did not feel that the support for changes in the length of the firm was sufficiently strong at present to justify change and concluded from the questionnaire that given the suggested alternatives the present 8-week firms represent a reasonable compromise. We feel very strongly that most students have been most concerned about the quality of the individual firms in terms of experience and teaching and that it is in this area that improvements in the course must be made.

In this respect one major issue emerged from this questionnaire about which students felt unanimously. In clinical medicine experience is without doubt the best teacher and the new course has increased the amount of clinical experience available as it were "per unit student" by setting up new firms at Lewisham and New Cross, and introducing the first year elective of 6 weeks as an opportunity for further time in a busy regional district hospital as well as a 10 week period in a regional hospital in the 2nd clinical year. We feel that students derive tremendous benefit from these opportunities and would like to see an increase in the time spent in regional hospitals. The response to the question

Which of the following suggestions do you agree with?

(a) moving another surgical firm from Guy's to a regional district hospital;

(b) leaving the present arrangement (with 5 out of the 6 surgical firms based at Guy's and one at Lewisham);

(c) neither (a) nor (b).

met with an overwhelming 85% support for moving another surgical firm from Guy's. At present 5 out of the 6 surgical firms are based at Guy's compared to 3 of the medical firms. Students therefore we feel have less surgical experience and correspondingly less "effective" teaching. The response to this question is so decisive that we feel that it reflects that surgery is a subject at Guy's that needs improvement.

Questions concentrating on the place and quality of specialties within the course revealed that the majority of students (86%) felt that cardiology be moved from Surgery III to a medical firm (possibly a swap with gastroenterology) but that most felt that 2 weeks was necessary for anaesthetics. The suggestion that eyes be moved from Surgery II and swapped with urology at present with the dermatology/community medicine firm in the 2nd clinical year met with a 69% support from the small number who had completed both. A rating of the specialties showed that chest medicine, eyes and anaesthetics were considered to be "taught best" while rheumatology, geriatrics and nephrology were "taught worse".

The suggestion that individual lecture courses within each medical and surgical firm covering the topics of each specialty systematically would be an improvement on the present systematic clinical lecture series received almost unanimous support (92%). Such courses do exist for most of the 2nd year subjects and for eyes and E.N.T.

The systematic clinical lecture series received a poor assessment with 55% of students assessing it overall as little use, 11% as no use and 31% as useful. As a committee we feel that the scheme suffers from two major handicaps. The first is the timing in late afternoon. No other time is available in which all students can attend. The second is the fact that it is difficult for students to derive much from lectures in isolation. Often during the systematic series the topic may be cardiology, e.g. cardiomyopathies, while at least half the students are involved in a surgery firm with their minds and reading (hopefully!) attuned to acute abdomens and hernias. The solution we feel is to try to develop separate lecture/tutorial courses for the various specialties covering the subject systematically during each firm of students.

THE FIRM DINNER

The firm has ended, for the M.C.Q. is over and the last dreary afternoon in out-patients' has passed. Now all that remains is a little bacchanalian festivity. We happy band of medical students descend upon the kitchen and begin the frantic preparations. Initially, turmoil reigns supreme as hoards of fumbling male hands, unfamiliar with a dish-cloth let alone a rolling-pin, chop and mix and nibble their way through the ingredients. Minor disasters occur—the pastry cases collapse, the cream stubbornly refuses to be whipped and the jelly remains liquid. However, the custard with its intransigent lumps proves to be the biggest headache. We stir it, whisk it, boil it and finally attempt to strain it but it just sits there in a steaming, pernicious yellow mound quite uncompromising over its lumps. Meanwhile, sizzling quiches emerge from the oven, salads burgeon forth and sumptuous gâteaux are created.

At last, all is ready though only in the nick of time. We dash away to change, then rapidly regroup as the guests appear. Consultants arrive and acknowledge each other with barely perceptible nods before drawing a crowd of acolytes about them. We sadly lament the singular absence of wives and turn to the wine for solace.

Time glides onwards and both food and drink magically disappear into undreamt of caverns. Then, the alcohol begins to reap its toll. Does the urologist really have rosacea or the dermatologist a touch of prostatism? A surgeon stretches out upon a dining-room chair and launches into a eulogy on the Australia Antigen. The sound of this sonorous monologue lulls his audience to blissful sleep. Apocryphal stories abound; Mr. F , a veritable natty dresser, relates with marvellous sesquipedality the contents of his wardrobe. We visualise his 150 suits being conscientiously brushed, and pressed and laid out by a team of ravishing Philippino girls, not to mention the fleet of seven Rolls Royces driven by Philippino chauffeurs and presently marooned in a terrific jam on the South Circular Road! A political debate then erupts, meanwhilst assiduous students keep the consultants' glasses topped up. With rising meniscus and surface tension against them, these famous men sup back our innocent little wine.

Midnight draws near and our guests instinctively glance at their watches. A surgeon mutters an excuse about an 8 a.m. operation, whilst a careful physician declares, "It's long past my bed-time. I've got to look after myself especially now I'm on tablets". All persuasion to have another glass of "the red stuff" fails and our bunch of Cinderellas melts away. They tumble down the stairs and out into the cold, damp night like children from a Christmas party. We pull the door to and lapse into oblivion.

C.M.H.

NURSING

The Nursing Process

For the past year, nurses have become increasingly obsessed with the "Nursing Process". Papers have been written, seminars and discussions held, in order to ensure that each and every one becomes indoctrinated. For those

who were finding that the novelty of "Salmon" and the Health Service Reorganisation was beginning to wane, this has provided a new interest, and a fresh bandwagon on which to jump.

One may be led to ask what is the nursing process and what has stimulated this sudden upsurge of enthusiasm?

In simple terms it means planning the care of patients and actually taking some interest in them as people, instead of treating them as items on a conveyor belt, which has for so long been the case. It is in fact, what nurses should always have done, and in which area they have been totally negligent, so intent were they on acting as hand maidens to the doctors. It is therefore difficult to discern whether or not the new found interest is merely an attempt to reconcile feelings of guilt.

One might also ask how the system works. It means that when a patient is admitted, a nurse has actually to sit down and talk to him in order to establish his needs. An activity which is somewhat foreign to many of the profession. A plan of care is then formulated, aimed to consider the best interests of the patient. This plan should be flexible enough to incorporate changes in the condition and treatment of the individual.

In areas catering for adult patients, this has come as a revolution. Never before has such consideration been given to individuals, they were merely thought to be difficult if they did not conform to a predetermined routine.

In Paediatric units however, the staff are watching these developments with great interest, and not a little amusement, since in such areas the practice has been commonplace for a very long time. One cannot nurse children without planning their care in considerable detail, which is probably why their nurses are regarded by their colleagues as obsessional. It is however true that at the present time paediatric nurses could teach others a great deal, and cannot understand the necessity for the excitement over something which should always have been practiced.

It is intriguing to watch nurses' reactions to the innovation. At present their behaviour resembles terrier dogs worrying their prey. In five years time they will probably have abandoned the idea as impractical, in order to enthuse over something different. If however, the profession had always practiced efficiently, there would have been no necessity for the introduction of the "nursing process", since such care would have been routine.

Pam Jeffries.

PHYSIOTHERAPY

Dr. John Williams, Secretary of the British Association of Sport and Medicine, was speaking to the Physiotherapists and Radiographers Association at Guy's recently, and he went straight in to say that physiotherapists are very bad at treating sports injuries. Good, he added, at treating injured sportsmen but bad at treating their injuries.

Well, of course, the radiographers were not much affronted by this, let alone taken back, but it did cause a little pursing of the lips and blenching of the cheeks amongst their physiotherapist colleagues. The point being made, I think, was that physical though the therapy may be, its *raison*

d'être is far from *raisonnable*, and that the psychological effect of having someone caring for and intimately concerned with the sportsman and therefore with his injury, is more beneficial to that injury than anything the physiotherapist actually does to it directly.

It's rather a disturbing thought, even if not a new one—are we untrained psychotherapists in practice rather than the highly trained physiotherapists that we are in theory? Well, of course, why just us? Why not all our colleagues in the "caring" professions? Why not, in fact, Dr. Willliams? He, I do not doubt, would agree that a proportion of his success is attributable to the interest he takes in his patients but at least he can demonstrate that what he actually does to them is helpful to them as well. But we can't. All we can say is that we gave this damaged games-player a course of ultra-sound and ice, followed by deep massage and a graduated programme of exercises, and he got better. Well, that's not a bad thing to be able to say—but it begs the question—would he have got better as quickly if we had left him alone?

It really is time that those of us practicing physiotherapy—and similar arts, crafts and sciences—got to grips with the methodical, disciplined, detailed and prolonged scrutiny of our results and their applications and were able to respond to the challenge—for that is what it was—of Dr. Williams and our other well-intentioned critics.

Research is a word much bandied about at this time, and to be doing a bit of it might mean anything from reading the same textbooks that everyone else took to be standard reading anyway, to the most esoteric statistical survey of some polysyllabic chemical which is demonstrable only in the eye of a newt or the wing of a bat following prolonged heating at Regulo 7. Research as an end in itself is a bit like a degree course in Anglo Saxon syntax, fascinating but with little relevance in the present and still less in the future.

Not that we seem to be rushing helter skelter into the arena—according to the report of the Research Special Interest Group of the C.S.P. only a handful turned up to a recent well-publicised open meeting. That is not necessarily to be deplored—better the few who are interested and able than the many who are there because it's a Good Thing—but it should compel those of us in institutions like Guy's to ask ourselves if we are taking our rightful place in the brave new world.

Ronald Cooper.

CORRESPONDENCE

What is wrong with the N.H.S.—a reply from across the "Pond"

Sir,

My astonishment at Dr. Armstrong's article "What is wrong with the N.H.S.?" and his final conclusion "that there is nothing fundamentally wrong with it" (*Gazette*, 28th of January) is in no way diminished by the time it takes mail to cross the Atlantic.

I suspect that many providers of care under the N.H.S.—and perhaps some of the recipients too—will share my surprise at Dr. Armstrong's failure, in the space of some two pages, to make any worthwhile comment on the state of the service, but perhaps the most interesting aspect of Dr. Armstrong's article concerns what must be his own massive imperturbability in the face of a collapsing, third-rate, impersonal and finan-

cially-hamstrung apology for a health-care delivery plan.

The marvel is that the scheme functions at all, and surely that must be a tribute to the patience of Britain's doctors, nurses and ancillaries who, in the face of bureaucratic top-heaviness, ministerial ineptitude and severe financial restraint, have somehow contrived to provide some sort of service. It would be interesting to speculate on the current state of health-care in the United Kingdom if the foregoing groups of health workers were to join the serried ranks of the trades unionists, who nowadays apparently feel that hospitals are legitimate battlegrounds and the patients suitable pawns in the pursuit of demands and the redress of their grievances.

It is difficult to credit that any fair-minded individual who is endowed with a minimum of perception could not draw up a list of ills—by no means exhaustive—when considering the National Health Service. Here are some of my own, some current and some long-standing:

1. Direct control by central government is unwieldy, and the chief executive, the Minister, is too often inept and as often as not antipathetic to the health professions, thus making any sort of harmonious working relationship impossible.

2. On a more topical note problems abound. Dr. Armstrong's thesis "that the N.H.S. is a crisis of knowledge and social values" (whatever this may mean), will hardly explain the deplorable state of the Liverpool Health Authority, which has 1200 empty beds in its area of jurisdiction, nor will it comfort the inhabitants of Sheffield, whose new Royal Hallamshire Hospital lies empty. And I suspect it will do little to ease the pain of the thousands of orthopaedic patients who cannot receive, within any reasonable time-span, the surgery that their various conditions demand.

3. The National Health Service is directly responsible for the emigration of literally thousands of doctors and nurses—there are, at best count, over two thousand British or British-qualified doctors in British Columbia and Alberta alone. This represents the biggest migration of skilled personnel since the persecutions of Hitlerite Germany, and surely no country can withstand the loss of its professional classes on such a massive scale. But, with the bland indifference of officialdom, since quality is not an accepted criterion, their vacant jobs are filled with applicants from undeveloped areas of the world.

Space precludes any more exhaustive analysis of Britain's health-care woes; that they exist is undoubted and whether they can be righted under the existing arrangements highly unlikely. I, for one, hope not, for I believe that only a return to a less restrictive form of service would restore Britain to the top of the league in the sphere of medical services and her rightful place in the international world of medical science.

Yours faithfully,

D. M. SMITH.

Edmonton,
Alberta.

Private Hospitals and Medical Care

Sir,

I much admired your Editorial on this subject in the *Gazette* of 27th May. May I add two points to strengthen your argument in favour of private care while the need persists?

On the argument that private care gives the "rich" an advantage over the rest I find that in rural practice it is not the rich who belong to B.U.P.A. and P.P.P. but the small farmer or business man who cannot afford to wait and take it easy when his hernia needs to be repaired—taking it easy for eighteen months could ruin his farm or his business. Likewise the small farmer cannot take time off if his name comes up at hay or harvest time. He needs to have his time off in the winter when the land is quiet.

Secondly, any person in any income bracket has the right to spend what money he has left after tax and N.I.C. how he likes. One of the self-styled "non-rich" has no right to accuse one of his peers of privileged treatment or queue jumping if his peer chooses to put his money into B.U.P.A. or P.P.P. rather than the instalments on a car, a caravan or a holiday on the Costa Brava. Providing society is not hurt, and it is not in this context as you say yourself, we must be free to spend our money as we please.

Yours faithfully,

JOHN V. KILBY.

Kimbolton,
Huntingdon, Cambs., PE18 0HD.

Love all on the courts

Sir,

What's happened to all the squash and tennis players at Guy's? Times are bad when a tennis match is conceded because we can't put out a team, and all three squash teams do so badly in the league that one is relegated and another is withdrawn by us altogether.

Why, one wonders, are people reluctant to compete for places in the teams and play regularly in matches? Perhaps, it's the dribble of cold water masquerading as the shower facilities in the squash changing rooms that puts them off. I doubt, however, if the situation will improve when the new courts are in use.

It's high time that good players in either sport became less apathetic about playing for the hospital. With a wider pool of players, the standard might even improve.

Yours faithfully,

A. T. MORGAN.

Boland House,
Guy's Hospital, SE1 9RT.

Apathy!

Sir,

Over the last few years there has been a noticeable decline in the interest students take in the organisation and running of all the Clubs' Union activities.

The last few General Meetings have been inquorate, but to allow the Union to function the meetings have continued. All the votes taken at these meetings have been considered by Union officials as a representative opinion of the student population. With such important matters as the complete revision of our constitution, the incorporation of paramedical disciplines into the Union, pre-registration jobs and the representation of Guy's students at London University and other external meetings, might we be, by our apathy, leaving ourselves open to manipulation and abuse by an emotive minority?

Even down at club level, the rot seems to have set in, with a number of clubs finding it difficult to form an efficient management committee or even field teams. At this years' Summer Festival and Sports Day all constituent clubs of the Union were given the opportunity to run a side-show to earn themselves some extra cash and "sell" their club; the initial response was good, but on the day only two clubs could be bothered to turn up. The Athletic events also were only supported by a small number of students.

The facilities available to all students at Guy's are probably some of the best provided to any students within London Universities, are we not missing the opportunities afforded to us by the Union, which could perhaps be considered as part of our education.

The complaint may be due to our present constitution, Union officials or a whole host of other reasons. The prognosis is only good if we are all willing to participate.

Yours faithfully,

NICHOLAS TAYLOR.
Athletic Clubs Committee Sec.

Boland House,
Guy's Hospital, SE1 9RT.

Ruddigore

Sir,

Dr. Jenkins' letter (Gazette, 29th April) brought back memories of the orchestral pit, largely below the front part of the stage, at the Fortune Theatre.

The first trumpet, a carpenter from the Hospital Works Department, was clear of the stage while standing to play the National Anthem; the second trumpet, a tall (6′ 5″) medical/dental student, was not, and with head bowed, had to direct his instrument towards his feet.

Yours faithfully,

(Ex Buccinator),
W. GEORGE CROSS.

2 Grafton Close,
Christchurch, Dorset.

Still Houlding up the Bar

Sir,

Perhaps you would allow me to make one or two comments following the Bar Secretary's reply to my letter in the May 'Gazette'.

May I say first that I fully appreciate that as Bar Secretary, Mr. Matthews quite reasonably owes an obligation to his staff to defend them against what he describes as 'blatant accusations'. If my letter was couched in accusing terms, I apologise. My sole purpose was to lay out in the open a number of obvious exit routes by which the missing cash may have disappeared. I believe it is only right that in any situation assessment, a full exposure of alternatives be made, and it certainly isn't my fault if some of these appear to cast shadows upon the integrity of the Bar staff.

As regards the content of Mr. Matthews' reply, I should like to point out that he has done nothing to convince

me that any one of the possibilities I proposed should be discarded. He managed only to ridicule each suggestion by pointing out that such large sums of money could not conceivably disappear by that route alone: a point that should be clear to everyone. He makes no mention of being prepared to consider a combination of causes which makes me think he is far more anxious that the whole matter should slide gently into the oblivion of our fading long-term memories, than execute a degree of incisive thinking.

I am sorry that the Bar Secretary is so disappointed with my destructive criticism and bored with my lack of originality. I, on the contrary, am impressed by his stunning dynamicism in making such a constructive and original contribution to the task of solving this unfortunate problem.

We are thus entitled to expect a lot of Mr. Matthews; at the final count a satisfactory explanation at the very least.

We may have to wait a little—such giants move slowly.

Yours faithfully,
TIMOTHY HOULDING.

St. Stephen's Lodge,
Hankey Place,
London, SE1

BOOK REVIEWS

"Davidson's Principles and Practice of Medicine", Ed. John Macleod, 12th Edition. Pp. 978. Price £6.50. Published by Churchill Livingstone.

A new edition of "Davidson's" is assured of a place in libraries and on many student bookshelves the moment it appears. It is one of the more consistently excellent textbooks for the undergraduate, and the 32 contributors provide a solid underpinning of knowledge across the whole range of medicine. The range is particularly broad for a "small" textbook in that 127 pages are dedicated to tropical diseases, perhaps reflecting the book's popularity in Africa and Asia. Such depth and thoroughness are characteristic and generally laudable, but this may actually inhibit some undergraduate readers when the style becomes rather heavy with detail and loses that emphasis on features of prime importance, and overall clarity, needed by the newcomer to medicine. The book is not designed as a reference textbook (such as Cecil & Loeb or Harrison) so it occupies a place intermediate between those and the shorter textbooks. One must add that some chapters such as that on psychiatry by H. J. Walton, are marvellous by all criteria. It is a first class book, one that you should examine before you buy a medical textbook, but it may or may not answer your particular learning needs.

BRENDAN HICKS.

"Manual of Surgical Intensive Care", by The Committee on Pre and Postoperative Care, American College of Surgeons. Pp. 335. Price £9.50. Published by Saunders, 1977.

This book is published through the Committee on pre and postoperative care, of the American College of Surgeons and has a highly distinguished list of American contributors. The book is in three parts: Development of surgical intensive care; General aspects of surgical intensive care and Management of specific conditions, and the various chapters are written by a fair mixture of surgeons and anaesthetists. The general tone throughout the book emphasises basic clinical knowledge and although it mentions most of the modern developments in intensive care, the authors continually remind us that examination of the patient remains the most important investigation. Part I of the book traces the development of modern intensive care and the problems involved in starting, designing, administrating, staffing and equipping the unit, and though these chapters are relevant to someone involved in these tasks, there is little of relevance to the house staff involved in the practical management of patients. The difficulties of admission policy are discussed, reminding us that intensive care should not merely be support for surgical failure, and also emphasising to all those who work in these units that death is not the ultimate failure. It is worth pointing out that the commonest causes

of complaint from the patients are the exquisite pain of tracheal suction and the effects of idle talk by the attendant staff. There is also an interesting list of the training requirements for an intensive care nurse in America, including many procedures that doctors here would find difficult to emulate.

Parts II and III are a much more practical approach to the management of the patient and in general are very well written. Particularly good are the chapters on ethical and legal considerations in intensive care, the use of blood components and psychiatric considerations of intensive care, though of course some of these do not yet apply to this country. The specific management section covers infection, ventilatory complications, peripheral circulatory failure, cardiac problems in the surgical patient, renal failure and burns. The chapter on ventilatory complications is well written, with a good review of positive end expiratory pressure, as is the long chapter on the care of burns.

There are always minor criticisms. The use of abbreviations is particularly annoying in the book; in fact ARF is used to mean acute renal failure and acute respiratory failure and everything possible seems to have been relegated to abbreviated capitals.

The treatment of ventricular fibrillation gives good advice but does not mention doses for calcium chloride, sodium bicarbonate (surely "one ampoule" is an inaccurate way of advising treatment) or isoprenaline infusions. The use of steroids is mentioned but is not discussed, and those who have become involved using them probably realise there are very different views on their use..

There is no standard policy on the use of drug names as the book contains a mixture of proprietary and approved names; it would be much simpler if every drug appeared as the approved name with the proprietary name in brackets afterwards. None of the measurements in the book appear in SI units, and though this is the current practice in America, it is unfortunate for those who are just becoming used to using them that they do not deserve a mention. A short section of postoperative shivering in association with heart failure omits the use of oxygen and has the suggestion that paralysis and ventilation may be necessary as suitable treatment, a procedure that might be considered just a little drastic. The most unfortunate omission is a chapter on intravenous nutrition, though this was the subject of a manual by the same Committee published in 1975. Finally almost all the references refer to American sources.

All in all an excellent summary of the basics of intensive care though perhaps some unnecessary space is allocated to the first part of the book.

M. A. THOMPSON.

"Viral Diseases of the Fetus and Newborn" by Hanshaw and Dudgeon. Pp. 356. Price £14.00. Published by Saunders.

This volume is No. 17 in a series dealing with major problems in clinical paediatrics, edited by Alexander J. Schaffer and Milton Markowitz. Topics in previous volumes have included juvenile rheumatoid arthritis, neonatal dermatology and paediatric nephrology, and there are to be future titles such as juvenile diabetes and otitis media in infants and children.

Both authors are world experts on viral diseases in the fetus and newborn, and there is no doubt that they have made a thorough and up to date job of the subject. As they point out in the Preface, the discovery in 1941 that such a mild disease as rubella can lead to severe congenital defects led to the expectation that many other viruses would have the same effect, and although this has not proved to be the case, the few viruses that are incriminated have affected large numbers of children. Accordingly, a large proportion of the book is devoted to rubella and cytomegalovirus. There are smaller sections on herpes simplex, enteroviruses, varicella-zoster, smallpox-vaccinia, and hepatitis viruses. The clinical features, diagnosis and treatment have successfully been integrated with the virology, immunology and concepts of pathogenesis to give a coherent and modern account that is at the same time a pleasure to read. There are two well written and relevant chapters by other authors. One on the pathology of the placenta and cord by Dr. William Blanc, and one by Dr. William C. Marshall on the development of immune mechanisms in the fetus and newborn. But we have been spared the multiauthored incoherence of so many current volumes, and the unity of approach in this book is a tribute to good cooperation between the authors. I very carefully reread the chapters on rubella and cytomegalovirus just to make quite sure that all the nice things I had said are true.

CEDRIC MIMS.

"Bailey and Love's Short Practice of Surgery", 17th Edition, 1977. Revised by A. J. Harding Rains and H. David Ritchie. Pp 1,352. Price £17.50. Published by H. K. Lewis, 1977.

In this 17th edition many authors have collaborated in the writing or rewriting of chapters of this Standard British Textbook of Surgery. In particular, sections on bomb-blasts and terrorist warfare, and transplantation, are very relevant to our society. Certain sections, such as pancreatic function, have been updated to include such investigations as endoscopic retrograde cholangio-pancreatography, and in another section the EMI Scanner is briefly outlined. The quality of writing is in general high, but I think that in a work of this kind a few useful references should be included to guide the reader seeking further information in the right direction. After all, as the authors point out, the book is intended for both graduates and undergraduates, and as a means of reference. Unfortunately a number of the illustrations are very poor, and one or two are illegible even with a magnifying glass. They would be better removed or replaced. In addition, some aspects of treatment remain outdated—for example, the management of exomphalos major and hepatic injury.

However, despite the inevitable criticisms, which must surround a work of this kind the book can be thoroughly recommended to both graduates and undergraduates for the wealth of clinical information it provides. It differs from the big American text-books in that it concentrates less on the academic and more on the clinical and practical aspects of surgical diagnosis, and thus provides an important balance at a time when there is some danger of underestimating the value of clinical acumen and skills.

M. H. JOURDAN.

"Use and Interpretation of Renal Biopsy", by Gary E. Striker, Leonard J. Quadracci and Ralph E. Cutler. Pp. 347. Price £17.50. Published by Saunders.

This monograph consists of 26 concise chapters which are amply illustrated and easy to read, during short train journeys, and other similar stolen peaceful interludes. As the authors state in their preface, they have achieved a synthesis of clinical and histological information. Much as I agree that this should occur, I feel that this book is dominated by the clinical approach, which has been to the detriment of the pathology. The classification used is based on the form of clinical presentation which may be helpful to a registrar or consultant physician trying to understand renal disease but does little to help the pathologist interpret the renal biopsy. Since this book is Vol. 8 in the series Major Problems in Pathology one would be excused for thinking it was intended to be a book for the pathologist.

There are a number of minor errors and ambiguities in the text which could have been eliminated by more careful proof reading. The authors make use of frequent diagrams to explain the glomerular and vessel changes which may occur. Many of the diagrams are helpful but some are over-simplified or even misleading. I thought that the immunofluorescence data is too scanty in some sections and overtly incorrect in others.

The authors make considerable use of photographs of lum plastic sections. Some of these were helpful but quite a number were very unclear and would be better omitted.

I think this book is readable and would be of value to the clinician trying to understand renal pathology. I would not recommend it to pathologists who wish to learn how to interpret the changes which are seen in renal biopsy material.

DAVID TURNER.

"Introduction to Oral Medicine", by D. M. Chisholm, M. M. Ferguson, J. H. Jones and D. K. Mason. Pp. 290. Price £7.75. Published by Saunders.

There is a fascinating little game which may be played by oneself while reading the Oxford Dictionary of Quotations. It consists of following up references as one reads and several hours may be spent in this delightful pursuit. However, when reading text books it is extremely irritating to be continually bombarded with cross references, and this is undoubtedly the main defect of this book. For example, in Chapter 3—Development, Structure & Disorders of Development—cleft palate, hare lip and bifid uvula are mentioned, only to say "these defects are discussed in Chapter 16".

Aphthous ulceration, surely the mainstay of any oral medicine clinic, is discussed on two pages, whereas a whole chapter is devoted to such topics as The Roles of Dentist, Doctor and Hospital Specialist, referral of patients, and the Oral Medicine Clinic. Such an approach

is expected in American text books, but somewhat hard to accept in a British one. There is no mention of benign sensory trigeminal neuropathy under Neurological Disorders as a cause of anaesthesia, and the condylen neck fracture in Fig. 18-3 is not evident at all.

The book is beautifully bound and printed on glossy paper, but unfortunately contains no colour plates. Since it is primarily aimed at undergraduates, it is a pity that it was not bound more cheaply—as a paperback for example, and included colour illustrations. The black and white pictures are of rather poor quality, particularly those reproducing radiographs. The lateral oblique in Fig. 16.6 is the wrong way round and Fig. 19.4, which is described as "normal dentition at the age of 14", shows a case in which four premolars are missing either introgenically or congenitally. There is no mention of the oral aspects of systemic drug therapy.

At £7.75 this book can hardly be recommended to students, which is unfortunate as there is at present somewhat of a dearth of good oral medicine texts.

R.E.H.

SPORT

Over the past few months you have been able to read the summaries of the successes and failures of most of the sporting teams at Guy's in this magazine. Many people have spent hours scratching heads and gnawing at pens writing their recollections, humorous or otherwise for your perusal. I would like to thank all these correspondents who have made such an effort to contribute to the *Gazette* sports section. People that spring to mind for an extra mention include the highly articulate Gareth Parry, Dave Greenaway, Simon Perkins who always writes his reports on a sort of toilet paper covered in egg and shampoo, and an anonymous hockey player. It may be worth noting the rewards that come to *Gazette* correspondents—Gareth Parry and Simon Perkins have been elected captains of rugby and soccer clubs respectively, and Dave Greenaway is the secretary of the latter. So I would suggest that anyone who wishes to succeed in their sport should become a *Gazette* correspondent! Reading the last twelve months' sporting reports there are many gems of descriptive writing to be found. Dave Greenaway wrote in the same article that one player headed a football on the ground "like a grazing ox" whilst another stands accused of "redecorating one side of the pitch courtesy of the lower Spit", and Simon Perkins never plays in games that aren't remembered as "take no prisoners" battles.

Also, there is a record of the success and failure of all Guy's clubs in the *Gazette*—a relatively moderate season for the Rugby club, an unfinished year for the hockey club who would be rich if they had been given ten pounds every time someone cancelled a match against them and an excellent season for the soccer club. The latter had two teams promoted last year and have another team and a second pitch at H.O.P. to their club. Congratulations to them. Other teams have had marvellous tours including the Vipers and the first rugby team who went to America. The Hare and Hounds club made a surprising and excellent contribution, and there were *Gazette* reports by swimmers, mountaineers, sailors and cricketers.

In the next twelve months I hope there will be as many excellent reports with the same quality writing. It would be nice to have many more correspondents, and a few more action packed photographs. I note with pleasure that many clubs appoint P.R.O.s to become *Gazette* correspondents. Keep those reports coming!

The cricket team led by the enigmatic Alasdair Jacks have had an awful start to their season—all the first few matches were drowned in deluges. Let's hope that the recent fine weather affords a few matches for them.

Lastly I wonder if you have all enjoyed the World Cup as much as myself. I was bored by the football very early on, but kept watching because of those hilarious commentators. For me BBC have the pick of the bunch. John "for those of you watching in black and white, Spurs are in all yellow" Motson has not played as well as he might. His only gaff was "My goodness, it's gone straight through Alan Rough". For Barry Davies the Scottish team manager when his team were losing 3—1 had a face "like a well kept grave". My favourite is David Coleman who re-

marked about a move, "cheeky, arrogant, controlled and wrong!" The team of experts they line up are also amusing. Bobby "what friendly little chaps the Tunisians are", and John Bond with his "dicky starts" only offset James Hill's arrogance and condescending manner. Isn't it so interesting how well the foreign teams speak English—I wonder how many of the Scottish team speak Dutch, come to think of it I sometimes wonder how many of them speak English! Well I'm leaving the World Cup half over and going to Corfu to see why they didn't qualify—I know why England didn't they **Reviewed** the situation and made a **Cocker** up of it!

JOHN EARNSHAW.

GUY'S HOSPITAL BLUES COMMITTEE

Athletics Club

Half Blues: Tim Jennings, Nick Mansfield, Tim Wilkinson.

Association Football Club

Full Blues: Andrew Mitchell, Simon Perkins, Trevor Underwood.

Half Blues: Jonathan Earnshaw, Roger Davies, David Greenaway, Kenneth Harper, Neil Maclachlan, Tim Miller, Paul Shepherd, Keith Underwood.

Badminton Club

Half Blues: Philip Bolt, Les Bran, Diane Christopher, Robert Hannaford, Mark Harris.

Cricket Club 1977

Half Blues: Liam Hughes, Alasdair Jacks, Andy Mitchell, Jerry Ryan, Jeff Senior.

Fencing Club

Half Blues: Nicholas Barrie, Aubrey Bristow, Jonathan Lovett, Norman So.

Golf Club

Half Blues: Robert Heard, David Webber.

Hockey Club

Full Blues: Stephen Flint, Mark Harris, John Pascoe.

Half Blues: Shiraz Gulamali, David Keable Elliott, Martin Vallis.

Rugby Football Club

Full Blues: Mike Broughton, Graham Francis, Richard Laws, Gareth Parry.

Half Blues: Jonathan Beard, Paul Davenport, Howard Longton.

Sailing Club

Half Blues: Simon Girling, Andrew Houghton.

Squash Club

Full Blues: Jonathan Moore, James Farquharson.

Swimming Club

Full Blues: Mary Ganczakowskie, Michael Miller, John Taylor.

Half Blues: Jonathan Beard, Santanu Kahn, David Rickard.

Tennis Club

Half Blues: John Chaplin, Sarah Perfect, Jonathan Pringle.

THE SUMMER FESTIVAL SPORTS DAY HELD ON 20th MAY

Results

Marathon: Guy's Colonnade to Guy's Athletic ground, H.O.P.

Men—1st, J. R. Stephenson, 38 mins. 50 secs.; 2nd, M. O'Connor, 40 mins. 38 secs.; 3rd, I. Leonard, 42 mins 37 secs.; 4th, Dr. M. C. E. Hutchinson, 43 mins. 10 secs.

Women—1st, Mary Illingworth, 54 mins. 5 secs.; 2nd, Barbara Pilkington, 57 mins. 6 secs.; 3rd, Judith Tranter, 58 mins. 26 secs.; 4th, Cindy Orr, 60 mins. 38 secs.

Team Athletic Events

1st, Charterhouse Ark; 2nd, Not the Rugby Club; 3rd, Spirochaetes; 4th, Mountaineering club.

Men's Events

100m—1st, P. Cullinan, 12.5 secs; 2nd, R. Laws, 13.00 secs.

800m—1st. P. Cullinan, 2 mins. 17 secs.; 2nd, I. Leonard, 2 mins. 29 secs.

4 x 100m Relay—1st, Not the Rugby Club, 51 secs.; 2nd, Spirochaetes, 53 secs.

Discus—1st, R. Forest, 103 ft. 6 ins.; 2nd, P. Saunders, 83 ft. 4 ins.

Shot-Putt—1st, R. Forest, 30ft. 11 ins.; 2nd, A. Strachan, 29 ft. 1 in.

Long-jump—1st, G. Piggott, 16 ft. 11 ins.; 2nd, P. Keer, 15 ft. 10 ins.

Women's Events

100m—1st, L. Ramswoell, 14.5 secs.; 2nd, S. Lawrence, 15.0 secs.

800m—1st, A. Bereard, 2 mins. 35 secs.; 2nd, S. Knipe, 3 mins. 6 secs.

4 x 100m Relay—1st, Charterhouse Ark, 63 secs.; 2nd, Di's Devils, 66 secs.

Discus—1st, S. Jeffery, 45 ft. 9 ins.; 2nd, M. Marstrand, 43 ft. 3 ins.

Shot Putt—1st, L. Ramswell, 17 ft. 6 ins.; 2nd, J. Simmonds, 16 ft. 8 ins.

Long-jump—1st, L. Ramswell and T. Murphy, 10 ft. 0 ins.

Open Events

Men's

100m—1st, A. Searle, 12.8 secs.

400m—1st, K. Harper, 1 min. 50 secs.

Women's

400m—1st, S. Knipe, 1 min. 20 secs.

800m—1st, M. Taylor and N. Brackenbury, 3 mins. 52 secs.

Beer Race—1st, Spirochaetes.

Egg and Spoon—Junior—Steven Lawrence/Girls — Sandra Jeffery/Adults — Vincent O'Connor.

Five-legged—1st, M. Bower, Steve Hill, Miss J. Whellers, P. Norton.

Open Mile—1st, G. Manning, 5 mins. 41 secs.; 2nd, D. Hett, 5 mins. 43 secs.; 3rd, E. Heardon, 5 mins. 47 secs.

Tug-of-War—The Rugby Club.

Frisbee Competition—Peter Holmes.

Welly Throwing Competition (organised by The Rugby Club)—Gentleman's Event —Neil Matthews. Ladies' Event—Debby Pacy.

"Copper Coil" Competition (organised by The Mountaineering Club)—David Burton.

Five-a-side Football Competition—Men's League—The Surprised Sperm Whale. Ladies' League—Sticky Fissures.

Tennis Competition — Sue Berry, Richard Wellington.

CRICKET CLUB REPORTS

17th May: Guy's 70, Stoics 100

Having won the toss and put Stoics in, Guy's performed well in the field, none of the visiting batsmen getting to grips with some good bowling by Tunnadine (2—18), Williams (3—4) and Hett (2—30). The innings was concluded by a superb throw from deep square leg from John North to run out their startled No. 11.

In reply Guy's quickly lost wickets although Bruce Robinson (19) threatened to cut loose. Of the later batsmen only Tunnadine (22) looked at all at home, being the last man out.

Again a series of rather ungainly strokes contributed to our downfall.

25th May. Hospitals' Cup, 2nd Round Guy's 201—9, Middlesex Hospital 85

On a lovely day at Chislehurst, Guy's took first use of a soft but excellent batting wicket. After losing Broughton early on, Glover (43) and Jacks (23) batted freely for a while before a series of unnecessary shots reduced us to 122—7. However Mitchell (28) steadied the midde order batting before Leonard (30 not out) and North (12) provided a really excellent display of controlled hitting and quick single taking in the last 10 overs, to take us past the 200 mark in the allotted 60.

In reply the Middlesex quickly lost four wickets to Jacks and Shepherd and with the backing of a good total an all spin attack was introduced; Hughes and Hett requiring only fifteen overs between them to secure the match.

Guy's meet the Westminster in the semi-final at Cobham.

28th May
Guy's 123, Woldingham 125—3

The annual fixture at Woldingham was played in hot sunshine on Bank Holiday Sunday.

Winning the toss and electing to bat, Guy's began well but when Sheridan (21) and Glover (43) were out the middle order succumbed chiefly to Woldingham's ample leg-spinner. Only Mitchell (18) and Senior (19) provided any late resistance, taking Guy's total to 123 all out.

Wodingham quickly lost two wickets but then took complete command mainly through their captain—Mike Glover's brother—who flayed all our bowling (Mike's off-spin being summarily despatched for several sixes) and finished with 77 not out, Guy's losing by 7 wickets.

Our thanks must go to Mr. and Mrs. Glover for laying on such a splendid party in the evening.

3rd June
Guy's 123—4, Nomads CC 120

After last year's ignominious defeat, revenge was indeed sweet in this game. Losing the toss and being inserted, Nomads proceeded slowly to make very heavy weather of a somewhat uneven batting surface, taking three hours to make 120 all out, Jacks taking 3 for 11, Wright 3—22 and Williams unlucky to take only one wicket.

When we batted we lost two quick wickets, the first bowled attempting to hook a long hop that scarcely left the ground. However John Rees found the bowling well to his liking, hitting an excellent 62 (one 6 and eight 4's) and making things look quite easy. Shepherd gave him good support with 19. With nine overs left and needing 16 to win Robinson hooked two consecutive 6's and Tunnadine straight drove another to complete a good win by 6 wickets, in only 90 minutes.

4th June

Guy's 214, Highland Court 215—8

This traditionally enjoyable all day fixture played in lovely surroundings near Canterbury, and in warm sushine, provided plenty of excitement again this year. Having elected to bat on an excellent wicket we lost our first four wickets for 42 runs by 12.30 through little fault of ours. However Nield (67) and Jacks (33) restored decorum and when they departed had taken Guy's to 144 for 6, Nield's innings being a lovely display of footwork against spin bowling. A further period of stabilisation took us to 214 all out thanks to good batting from Sheridan (30) and Perkins (14).

Having lost their first five wickets for 95, Highland Court's sixth wicket pair maintained a run rate of 4½ an over until they had reached 198 with five overs left, when Wright bowled one member of the stand and had the other caught behind by Perkins (his fourth catch) in his next over leaving them 211 for 7 with two overs left. The eighth wicket fell with the score still at 211 but although every fielder was "saving the single" they managed to scramble the winning run off the fourth ball of the last over.

"JADES."

3rd TEAM SOCCER (Etc.!)

After an extremely successful season for the club, now that the congratulations and celebrations have subsided a little I feel that the magnificent achievements of the 3rd team should be highlighted for a moment or two. Although somewhat more modest than those of the 1st and 2nd teams, they have in their own way, led to perhaps the most radical change the soccer club has seen in many years, i.e. the formation of an official third team.

Mutterings of discontent from several quarters about the inability of the football club to provide regular games for many keen players, led, at the beginning of the season, to the formation of a social side, ready to assume the title of Guy's IIIrd's.

In the first half of the season the fixtures were coming in thick and fast and very often we were hard pressed to turn out a complete side. But thanks to a terrific response from all the lads, many of whom played, literally, at a moment's notice, no challenges were turned down.

I would like to thank all the people who have played for us this season (and there have been many) but there are several whose selfless devotion to playing "pointless" matches, on "disgusting" pitches, in atrocious weather is particularly worthy of note. These are: Mick "Müller" Corlett, John "Big-Stopper" Exelby, Mark "Leaping-Cougar" Billington, Bob "New-Boots" Bond and Steve Robinson whose incredibly biased refereeing has got to be seen to be believed. Also worthy of a special mention is Tom Alun-Jones. Tom, having survived many years and hard games of rugby without injury, offered to step-in at the last moment when we were short of a goalkeeper, only to be taken to hospital after 20 minutes with a badly gashed eye after throwing himself courageously at the feet of an oncoming forward . . . silly bastard! Thanks Tom.

Inevitably, in the second half of the season games were not so forthcoming. This was due mainly to the bad weather and the fact that university teams were concerned with completing their league fixture list. However, the enthusiasm shown by the thirds this season has not gone unrewarded; we now have a place in the league for next season and the recently acquired second football pitch (for use by "working class" people and others) will ensure regular home, as well as away fixtures. So if you are keen on playing soccer next season but don't aspire to the dizzy heights reached by the 1st and 2nd team players don't despair, contact Steve Robinson or me (M. Black). We're not gonna win the F.A. Cup but I think we may surprise a few people.

Yours,

ROY OF THE ROVERS.

P.S.—None of our players has ever failed a dope test.

INTER-HOSPITALS SQUASH TOURNAMENT, 1978

This tournament which has been the centre of some concern for the last few years has at last taken on a new form. The tournament, organised by E.P.R. (European Public Relations) and sponsored by Reckit & Colman Pharmaceuticals, is now open to any hospital members rather than solely students, as it has been in the past. For Guy's this has certainly been a step in the right direction as at the present, the team strength is comprised mainly of hospital staff.

Our first match was against St. George's (the team tipped to win). Because both No. 1's were unable to make

the date only four matches were played. Ray Sharp had his finest and closest match of the whole tournament, which he finally won (3—2) much to the relief of the gallery of supporters. This win was attributed to his fitness and unfailing competitive spirit. Jonathan Webb did well to win (3—2) with his determination and concentration on the court which is second to none, even in games of this nature. Both Rob Kirschen and Jamie Farquharson had matches of some quality and although perhaps, not with the same pressures as the others. With the same approach and a common aim both proceeded to demolish their opponents to give Guy's a (4—0) win. Although this result was a little unexpected it boosted the team's confidence and team spirit.

In the second round we played Charing Cross who we beat convincingly (5—0), this took us through to the next round to play St. Thomas's. Although the matches were a little tighter we managed to cruise through with another (5—0) victory to take us on to the final against Mary's.

The arrangement of this final match proved difficult and the eventual date decided was far from suitable for us as two of our first three players could not play. Unwillingness by Mary's to co-operate and play these matches three days early meant we had to field two substitutes, Roger Lewis and Colin Holder.

Colin had a convincing and speedy (3—0) victory using his reaching overhead shots and fitness to outplay his opponent. Afterwards this team spirit was shown not only on the court but also in the gallery. Jamie came up against an opponent where a little more than his usually adequate running was required. Although he covered a lot of ground to equalise after being (2—0) down, he lost (9—7) in the fifth. Ray took the court keen for a quick victory. His application to matches of this sort is indeed a pleasure to watch. He won easily finishing with a favourite overhead smash to give him a (3—0) victory. Roger was meanwhile having a very tense and equal match next door. Displaying his ability to take any opponent to five he lost (10—9) in the fifth after a series of match points for both players. The match position now was (2—2) with the final result resting on Rob's shoulders. After a fiery start he won the first game easily, but seemed to lack winners thereafter, and although he did a lot of running was unable to prevent going down (3—1) to a cocky opponent.

Although the result was not totally desirable the drinks and buffet provided afterwards certainly were. In fact Ray liked the wine very much.

It was agreed that next year we would be back to do just that little bit better. The team was selected from: Ian Nicholson, Ray Sharpe, Jonathan Webb, Rob Kirschen, Jamie Farquharson, Roger Lewis and Colin Holden.

JAMIE FARQUHARSON.

GOLF — THE PRESIDENT'S MATCH

The President of the Golf Club, Mr. Brain, put his presidency on the line again on Sunday, 14th June, as the students and President's team prepared to do battle on the field of Tonbridge Golf Club. In the result of a victory for the students Mr. Brain would be forced to resign—for five years he has successfully resisted all efforts to depose him.

Contrary to tradition (which was to be the order of the day) the students' team arrived an hour early. Some casual putting practice interspersed with several strong tomato juices made us ready for anything—for some of us, anything like a good sleep.

The morning's three foursome matches started on time and the rain quickly followed suit. Whether it was due to the bad weather or the tomato juice will never be known but the students were 2—1 down at lunch. The time-honoured ploy of slight alcoholic intoxication was called into play by the students during the break; the theory was to keep the muscles loose but to have a clear head—rather difficult at the best of times.

Dr. Maudling opened his yearly betting book on the afternoon's matches. Amongst the more notable bets was £5 at 33—1 against the aforementioned doctor beating Bill Whitby.

The weather steadily improved throughout the afternoon as the singles proceeded. By early evening the students had won 5 matches with 1 drawn (culprit wishes to remain anonymous). Consequently Mr. Brain did not quite lose £165 and the students forced the first Presidential removal for five years by $6\frac{1}{2}$—$2\frac{1}{2}$.

After a short celebration in the bar, both teams returned to Mr. Brain's home for a very pleasant evening during which Professor John Trounce succeeded Mr. Brain as President. Professor S. Cohen became Vice-President and is sure of a Presidency soon.

Transport back to London was provided by Dave Webber in his open plan car with Guy Palmer navigating. Other passengers aided rear wheel grip by acting as ballast. Whatever terrors happened on that journey are best left undescribed but they were overshadowed by the good time had by all.

This stunning victory boosted the team's morale to unknown heights and we look forward to a foray with Barts in the final of the Inter-Hospitals Cup.

Team.—Guy Palmer (acting captain), Bill Whitby, Dave Webber, Robert Heard, Michael Craigen, Nicholas Page.

N. PAGE.

PAST v. PRESENT

Honor Oak Park, June 10th

Past 146, Present 149/8

Like Scotland elsewhere, the Past (otherwise known as Scott and Munro's XI) again failed to do themselves a good turn in this annual contest. Winning the toss and batting on a wicket which proved to have some shooters and lifters concealed in it, the Past were quickly reduced to 22/4 by sensible bowling from Jacks and Shepherd, aided by some over-ambitious early-morning stroke play. Robinson (33), Wright (55), and Hey (18) restored them to the near riches of 126/5 at lunch.

But refreshments put new vigour into the Present attack and the rest of the veterans were soon gone. The total of 146 was never quite enough, though the Present found the going none too easy. Glover began as if to finish the match in an hour, until Henricus produced the unplayable delivery which he annually reserves for this batsman. It took some steady application by Shepherd (39), Leonard (20), and Plowman (22) to extract the runs from the ferocious Robinson (4/43) and the guileful Wright (3/48).

IAN MUNRO.

HOSPITAL INFORMATION

House Appointments
1st June, 1978

House Physicians

Dr. Scott/Dr. Joiner	Mr. J. J. Horton to 31.7.78
Dr. Gibson	
Dr. Grahame and	Mr. A. R. Johns to 31.7.78
	Mr. I. R. Martin to 31.7.78
Prof. Lessof/Prof. Keen	Mr. T. H. J. Goodship to 31.7.78
Prof. Dowling and Dr. Maisey	Mr. J. R. Britton to 31.7.78
	Miss A. L. C. Nixon to 31.12.78
Dr. Houston/Prof. Trounce	Mr. J. A. Pain to 31.7.78
Dr. Knight and Dr. Grimble	Mr. N. R. Womack to 31.7.78
	Mr. J. M. Twomey to 31.12.78

House Surgeons

Mr. Lawrie	Mr. I. D. Entwisle to 31.7.78
Mr. Ellis	Miss E. J. Dalgleish to 31.7.78
Mr. Beard	Mr. R. M. Buchdahl to 31.7.78
Mr. O'Flynn and Dr. Winter	Mr. J. Efthimiou to 31.7.78
Mr. Glover	Mr. D. L. Boone to 31.7.78
Mr. Maynard and Dr. Tong	Mr. D. G. St. J. Collier to 31.10.78
Prof. McColl, Mr. Rendall and Mr. Bewick	Mr. J. D. Taylor to 31.7.78
	Mrs. G. J. C. George to 31.7.78

Gynaecological House Surgeon

Mr. Coltart and Mr. Tomkinson	Mr. C. S. Bull to 31.7.78
Mr. Lewis and Mr. Morris	Mr. N. J. Masters to 31.12.78

Throat and Ear House Surgeon

Mr. P. K. Goutam to 31.7.78
Mr. G. Murphy to 31.12.78

Orthopaedic House Surgeon

Mr. R. Coates to 31.7.78
Miss F. J. Henderson to 31.7.78
Mr. L. B. Pritchett to 31.7.78

Genito-Urinary House Surgeon

Mr. R. Jooma to 31.7.78
Mr. D. G. Collier to 31.12.78

Thoracic House Surgeon

(S.H.O.)	Dr. J. Glover to 31.8.78
(S.H.O.)	Dr. J. Gryf-Lowczowski to 30.6.78
	Dr. H. C. Wong to 31.7.78

S.H.O. to the Renal & Transplant Unit

(S.H.O.)	Dr. M. S. Phillips to 31.8.78
(S.H.O.)	Dr. A. H. Gershlick to 30.11.78

Children's House Physicians

(S.H.O.)	Dr. T. Y. D. Leung to 31.5.79
(S.H.O.)	Dr. A. J. MacRae to 31.8.78
(S.H.O.)	Dr. J. S. G. Bamforth to 30.11.78
(S.H.O.)	Dr. A. E. Brusby to 31.1.79
(S.H.O.)	Dr. T. G. Powell to 31.3.79
(S.H.O.)	Dr. N. A. Cooper to 31.8.78
(S.H.O.)	Dr. L. A. Broughton to 30.9.78
(S.H.O.)	Dr. J. R. Bayly to 30.11.78
(S.H.O.)	Dr. R. A. McCubbin to 31.1.79

Casualty Officers

(S.H.O.)	Dr. R. K. J. Forber to 31.8.78
(S.H.O.)	Dr. K. A. Collett to 31.8.78
(S.H.O.)	Dr. J. E. Bridger to 31.8.78
(S.H.O.)	Dr. T. M. Baylis to 31.8.78
(S.H.O.)	Dr. A. Bruce-Chwatt to 30.11.78
(S.H.O.)	Dr. C. V. R. Blacker to 30.11.78

Resident Obstetricians

(S.H.O.)	Dr. K. E. Allen to 30.9.78
(S.H.O.)	Dr. N. S. Nicholas to 31.8.78

Neurological House Physician

(S.H.O.)	Dr. G. W. G. Vevers to 31.8.78

Dermatological House Physician

(S.H.O.)	Dr. C. A. Holden to 31.8.78

Resident Anaesthetists

(S.H.O.)	Dr. J. D. McArthur to 31.8.78
(S.H.O.)	Dr. S. J. P. Ariaraj to 31.8.78
(S.H.O.)	Dr. J. M. Evans to 31.9.78
(S.H.O.)	Dr. R. M. Cash to 30.6.78

S.H.O. to Nuffield House

(S.H.O.)	Dr. D. J. Cole to 31.8.78
(S.H.O.)	Dr. W. C. Crozier to 30.11.78

House Physician in Child Psychiatry

(S.H.O.)	Dr. G. M. Holt to 30.9.78

S.H.O. to the Cardiology Department

(S.H.O.)	Dr. P. N. E. James to 30.9.78
(S.H.O.)	Dr. N. A. T. C. Hamdy to 30.9.78

S.H.O. to the Department of Ophthalmology

(S.H.O.)	Dr. R. Henderson-Smith to 30.9.78
(S.H.O.)	Dr. P. E. Kinnear to 31.12.78

S.H.O. to the Department of Psychiatry

Dr. Fleminger	Dr. H. Standish-Barry to 30.9.78
Prof. Watson	Dr. G. Milavic to 30.9.78
Prof. Watson	Dr. G. J. Murphy to 30.9.78

ST. OLAVE'S HOSPITAL

House Physician	Mr. A. B. Tanqueray to 31.7.78
	Mr. C. B. Archer to 31.12.78
House Surgeon	Mr. A. K. Kapur to 31.7.78
	Mr. P. Emery to 31.7.78
S.H.O. in Gynaecology	Dr. S. R. Killick to 31.8.78
S.H.O. in Psychiatry	**S.H.O. IN PSYCHIATRY**
Dr. Fry	Dr. G. A. Walford to 30.9.78
Dr. Gaind	Dr. D. J. Nutt to 30.9.78
Dr. Gaind/Dr. Fry	Dr. P. H. Hollis to 30.9.78

NEW CROSS HOSPITAL

House Physician in General Medicine with Geriatrics and Rheumatology	Mr. M. G. N. Bourne to 31.7.78
	Mr. S. M. Milner to 31.7.78
	Mr. D. D. I. Wright to 31.12.78

BECKENHAM HOSPITAL

House Physician to Dr. Rawlings and Dr. Joiner	Dr. P. H. Jarrett to 31.7.78
House Surgeon to Mr. Hickton, Mr. Stevenson, Mr. Williams and Mr. Kinder	to 31.7.78

GREENWICH DISTRICT HOSPITAL

House Physican to Dr. Hartley and Dr. Thomson	Mr. S. S. Chan to 31.7.78
	Mr. R. H. Jones to 31.12.78
House Physician to Dr. Mallinson and Dr. Blower	Mr. J. F. McNulty to 31.7.78
House Physician to Dr. Colover and Dr. Marsden	Mrs. G. M. Dick to 31.7.78
House Physician to Dr. Mallinson	Mr. C. M. C. P. DeSousa to 31.12.78
House Surgeon to Mr. Park for 3 months and 3 months with Mr. Stoker and Mr. Harrison	Mr. J. F. Rivett to 31.7.78
	Miss B. A. B. McEvedy to 31.7.78
	Mr. B. Jones to 31.7.78
	Mr. P. N. Gaunt to 31.7.78
House Surgeon to Mr. O'Flynn, Mr. Wilson and Mrs. Wengraf	Mr. M. G. Pike to 31.12.78

ASHFORD HOSPITAL, KENT

House Surgeon	Mr. G. J. Hughes to 31.7.78
	Mr. J. Brennan to 31.7.78

HITHER GREEN HOSPITAL

House Physician in General Medicine and Infectious Diseases	Mr. B. A. Price to 31.7.78
	Miss S. A. Staples to 31.7.78

LEWISHAM HOSPITAL

House Physician to Dr. Price	Mr. J. C. Kingswood to 31.7.78
House Physician to Dr. Stott	Mr. D. V. Rajaratnam to 31.7.78
House Physician to Dr. Staffurth	Mr. R. P. Money to 31.7.78
House Physician to Dr. Llewellyn-Smith	Mr. M. K. Bancroft-Livingston to 31.7.78
House Surgeon to Mr. Lynn Evans	Mr. T. J. Palmer to 31.12.78
House Surgeon to Mr. Ivo Smith	Miss M. E. Heber to 31.7.78
House Surgeon to Mr. Monty	Mr. J. B. Warren to 31.7.78
House Surgeon to Mr. LeBrun	Mr. D. Kipling to 31.7.78
House Surgeon to Mr. Negus	Mr. L. C. Koo Seen Lin to 31.7.78
House Surgeon to Mr. Bevis	to 31.7.78

ORPINGTON HOSPITAL

House Surgeon to Mr. Wilding and Mr. Lam	Mr. D. J. T. Wright to 31.7.78
	Mr. A. P. J. MacDonald to 31.12.78
House Surgeon to Mr. Walker Brash and Mr. Ratnesar	Miss S. G. Overall to 31.12.78

House Surgeon to Mr. Boxall and Miss Austin — Mr. D. C. Markwell to 31.7.78

House Surgeon to Mr. Walker Brash and Mr. Glasspool — Mr. C. J. Forsyth to 31.7.78

House Physician to Dr. Southwell, Dr. Williams and Dr. Wharton — Mr. R. S. Hurwood to 31.7.78; Miss I. Lolin to 31.12.78

PEMBURY HOSPITAL

House Surgeon to Mr. Gibson and Mr. Lavy — Mr. J. J. McCarthy to 31.7.78; Mr. S. A. Watson to 31.7.78

House Physician to Dr. Maw, Dr. Everest and Dr. King — Mrs. L. M. Brown to 31.7.78; Mr. C. B. Ackner to 31.7.78; Mr. H. Watkin to 31.12.78

ST. HELEN'S HOSPITAL—HASTINGS

House Physician to Dr. Irvine and Dr. Strouthidis — Mrs. S. D. Nath to 31.7.78; Mr. F. Carabott to 31.12.78

ST. NICHOLAS' HOSPITAL—PLUMSTEAD

House Physician to Dr. Scott — Mr. M. L. Moss to 31.7.78

EDGWARE GENERAL HOSPITAL

House Surgeon to Mr. Qureshi — Mr. A. D. Bundock to 31.7.78

DISTRICT GENERAL HOSPITAL, EASTBOURNE

House Physician to Dr. Macleod — Mr. M. A. James to 31.7.78

WEST SUFFOLK HOSPITAL, BURY ST. EDMUNDS

House Physician to Dr. Evans — Miss A. Manktelow to 31.7.78

JOYCE GREEN HOSPITAL—DARTFORD

House Physician to Dr. Goldman — Miss S. G. Mitton to 31.7.78

House Physician to Dr. Wise — Miss B. Shah to 31.7.78

CUCKFIELD HOSPITAL—SUSSEX

House Surgeon — to 31.7.78

BUCKLAND HOSPITAL—DOVER

House Physician in General Medicine and Infectious Diseases — to 31.7.78

to 31.7.78

ISLE OF THANET HOSPITAL—RAMSGATE

House Physician to Dr. Cocking — to 31.7.78

DREADNOUGHT SEAMEN'S HOSPITAL, GREENWICH

House Surgeon — to 31.7.78

to 31.7.78

House Physician — to 31.7.78

ST. MARY'S HOSPITAL—EASTBOURNE

House Physician to Dr. Linley Adams — to 31.7.78

FARNBOROUGH HOSPITAL—KENT

House Surgeon to Mr. Hickton — to 31.7.78

PAPERS BY GUY'S MEN

Bell, G. D., Murphy, G., Dowling, R. H. *and others.* Effect of ioglycamide (Biligram) on bile flow and biliary lipid secretion in man. **Gut,** 1978, **19,** 300.

Bewick, M. *and* Rudge, C. J. Complication of the infusion pump. (Correspondence.) **Lancet,** 1978, **1,** 1043.

Bingham, J. B., Hilson, A. J. W. *and* Maisey, M. N. The appearances of renal transplant lymphocoeles during dynamic renal scintigraphy. **British Journal of Radiology,** 1978, **51,** 342.

Brown, D. *et al.* Dental materials: 1976 literature review. **Journal of Dentistry,** 1978, **6,** 1.

Buisseret, P. Dd., Youlton, L. J. F., Heinzelmann, D. I. *and* Lessof, M. H. Prostaglandin-synthesis inhibitors in prophylaxis of food intolerance. **Lancet,** 1978, **1,** 906.

Chilvers, C. E. D. *and* Cameron, J. S. Matching renal grafts. (Correspondence.) **Lancet,** 1978, **1,** 1047.

Crome, P., Widdop, B., Volans, G. *and* Goulding, R. SI, moles and drugs. (Correspondence.) **British Medical Journal,** 1978, **1,** 1277.

Edwards, A. C., Meredith, T. J. *and* Sowton, E. Complete heart block due to chronic chloroquine toxicity managed with permanent pacemaker. **British Medical Journal,** 1978, **1,** 1109.

Gardiner, P. A. *and* others. Vision screening in children tested at 7, 11, and 16 years. **British Medical Journal,** 1978, **1,** 1312.

Gillman, P. K. Ward rounds. (Correspondence.) **British Journal of Psychiatry,** 1978, **132,** 526.

Gosling, R. G. Doppler ultrasound assessment of occlusive arterial disease. **Practitioner,** 1978, **220,** 599.

Hayler, A. M., Holt, D. W. *and* Volans, G. N. Fatal overdosage with disopyramide. **Lancet,** 1978, **1,** 968.

Henderson, R. G. The position of the nutrient foramen in the growing tibia and femur of the rat. **Journal of Anatomy,** 1978, **125,** 3, 593-599.

Lehner, T. A vaccine against dental decay. **New Scientist,** 1978, **78,** 216.

Meredith, T. J., Crome, P., Volans, G. *and* Goulding, R. Treatment of paracetamol poisoning. (Correspondence.) **British Medical Journal,** 1978, **1,** 1215.

Murrills, A., Shelley, T. *and another.* Measurement of the fetal heart rate during pregnancy by a new electrocardiographic technique. **British Journal of Obstetrics and Gynaecology,** 1978, **85,** 12.

Murrills, A. *and another.* Patterns of fetal heart rate during normal pregnancy. **British Journal of Obstetrics and Gynaecology,** 1978, **85,** 18.

Poston, R. N., Cerio, R. *and* Cameron, J. S. Circulating immune complexes in minimal-change nephritis. (Correspondence.) **New England Journal of Medicine,** 1978, **298,** 1089.

Roberts, A. M. The origins of fluctuations in the human secondary sex ratio. **Journal of Biosocial Science,** 1978, **10,** 169.

Shillitoe, E. J., Wilton, J. M. A. *and* Lehner, T. Sequential changes in T and B lymphocyte responses to herpes simplex virus in man. **Scandinavian Journal of Immunology**, 1978, **7**, 357.

Starke, I. D. Long-term follow up of cardiac pacing threshold using a noninvasive method of measurement. **British Heart Journal**, 1978, **40**, 530.

Thompson, M. A. Routine procedures in general anaesthesia. (Correspondence.) **British Medical Journal**, 1978, **1**, 1275.

Viberti, G. C., Jarrett, R. J. *and* Keen, H. Increases glomerular permeability to albumin induced by exercise in diabetic subjects. **Diabetologia**, 1978, **14**, 293.

PASS LISTS

UNIVERSITY OF LONDON
M.Sc.—Human Communication

Ms S. Barlow
Ms L. Steiner

Ph.D.—Medicine

G. M. Ali (Human anatomy and experimental morphology)
Ms O. B. High (Histopathology)

Ph.D.—Science

F. S. M. Abulaban (Biochemistry)
Ms C. L. Mummery (Ultrasound)
K. J. O'Connor (Control of Hormone Production)

CHARTERED SOCIETY OF PHYSIOTHERAPY—May 1978

Final Examination

Mrs. C. M. Ratcliffe

Intermediate Examination

Mrs. Bondarenko
Miss G. A. Dobson
Miss R. A. B. Drewitt
Miss C. P. Kinloch Jones
Miss M. Marstrand

DEATHS

Dr. James L. le C. Walker, of Twickenham, formerly a Principal Medical Officer in H.M. Prison Service, died on 3rd May, 1978.

BIRTHS

FREELAND—To Chris and Andrew Freeland on 10th May, 1978 at The John Radcliffe Hospital, Oxford, a son, Tom, brother for Robert, Jeremy and William.

THOMSON—To Caroline and Rod Thomson on 26th May, 1978 at Pembury hospital, a daughter, Anna Rachel, a sister for Catherine.

CHANGES OF ADDRESS

Dr. and Mrs. Andrew Dawson, 18 Wells Close, Mickle Trafford, Chester, CH2 4DZ.

Miss Alison Healy, S.R.N., 16 Adam's Row, Mayfair, London, W.1. Tel. 01-499 9805.

PERSONAL

ENTHUSIASTIC but conscientious associate required for expanding mixed practice. Hygienist and laboratory available. Beaconsfield 3219 (day) Marlow 72100 (evening).

TIM HOPE- WYNNE, an established Life Assurance and mortgage advisor with Imperial Life Assurance Company of Canada, has been visiting and advising doctors and nurses at Guy's about their financial circumstances in relation to these matters. If you feel you would like his help contact him on 01-937 7292.

We should like to remind our readers that all copy for inclusion in the "Gazette" *must be received 12 days before publication.* Copy dates for the next 3 months are: 17th July, 29th July and 30th September.

Copy may be sent to us at 16, St. Thomas Street, S.E.1.

Birth, Marriage, Death and Change of Address notices are inserted without charge to subscribers.

When subscribers notify the "Gazette" of Change of Address, would they please indicate whether or not this should be published.

Personal notices are charged at 10p per word (pre-paid, minimum £2.00).

Non-subscribers are charged £2.00 (pre-paid) for all notices other than Death.

GUY'S HOSPITAL GAZETTE

ISSN : 0017-5870 Tel. No.: 01-407 7600 Ext. 2023

EDITOR ADRIAN PINI
ASSISTANT EDITOR PHILIP RAZZELL
NEWS EDITORS STEPHEN FENNY and CAMILLA HAW
SPORTS CORRESPONDENT JONATHAN EARNSHAW
NURSING CORRESPONDENT PAMELA JEFFERIES
PHYSIOTHERAPY CORRESPONDENT RONALD COOPER
RADIOGRAPHY CORRESPONDENT JILL GUEST
MANAGER LYN PAYNE

MONTHLY 29 JULY 1978 VOLUME 92 NUMBER 2284

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

Where have all the doctors gone?

About twenty students out of the eighty-six who had hoped to qualify as doctors by June this year have failed to do so. To those among us, who regard Guy's as one of the best teaching hospitals in the country, these results will no doubt come as a shock. But there is more to start Thomas Guy turning in his grave if the percentages for the individual subjects in the M.B., B.S. June results are analysed. A failure rate of 30% in surgery, 15% in obstetrics and gynaecology, 15% in clinical pharmacology and a relatively modest 9% in medicine have sent shudders through most clinical students and staff.

It is true that the M.B., B.S. results have never been Guy's forte. The average pass rate in the past four years has only been 76%, compared to this years 70%. Up to this year, however, most students at Guy's have taken the Royal Colleges' conjoint examinations so that very few have failed to qualify, and never as many as twenty.

Many at Guy's, and not without some justification, regard examination results as bearing no greater relationship to how able a doctor is, than the colour of a car bears to how well it works. So they are tempted to resist any efforts to improve performance and pass rates. But for those 20 students most of whom are competent, and all of whom will eventually qualify, failure means a considerable loss of confidence, and loss of six months earnings.

What then is going wrong? Some no doubt will blame the new clinical course. It is true that the rearrangement of the final year has prevented students qualifying on conjoint in the March before sitting M.B., B.S. in the June. This year students have been unable to qualify sooner, because of new conjoint regulations, and so most did not take up the additional insurance

of doing conjoint with M.B., B.S. One aspect of the new clinical course that needs improvement is the preparation given to students leading up to the exam. Certainly at the Westminster, and other medical schools, there is a "how to pass the exam" orientated brief revision course before finals. Other schools also provide more time between the last firm and the M.B., B.S., than the two weeks in Guy's new curriculum.

Making accurate comparisons of Guy's performance compared to the other medical schools in London is not really possible because of the many differences in parts that are school based as opposed to University based. In general Guy's has always been worse than the Westminster and Kings, and it may be significant that these schools are much more exam orientated. Indeed it is probably true to say that many of those students failing are not failing because of a lack of knowledge, but because of a lack of technique in facing examiners in the orals and clinicals. Technique is something that can, and should be taught.

The most notorious failure rate was in surgery which at 30% was three times that of medicine. This might be taken as a freak result on its own, but the recent S.M.E.C. questionnaire the results of which were published in the last issue of the *Gazette,* produced a startling 85% of students stating that they felt they were not getting enough surgical experience at Guy's, and backing the idea that another surgical firm be moved to a regional hospital. The examiners would seem to share this opinion of the students inexperience!

A major function of a teaching hospital is to produce good doctors. A necessary part of the process is that they pass the final examinations. It would appear that if Guy's believes it is producing good doctors it is not doing enough to make sure they pass their final exams first time.

Billion pound brain

"The greatest advance since Roentgen discovered the X-ray", "Medicine's miraculous new eye", "The X-ray of the future". E.M.I.'s brain and body scanners have collected ecstatic headlines almost as fast as international orders. Strangely we at Guy's have been rather on the sidelines as far as the billion pound brain is concerned (although E.M.I.'s manager of clinical development is Ray Joyner, an ex-Guy's man).

It looks increasingly as if our new Department of Radiology in Guy's Tower will have crumbled before a scanner is installed, while both King's and St. Thomas's have already taken delivery of their new scanners. Unfortunately it appears that our orders for X-ray equipment were placed before the brain or body scanner came on the market, and we may note with passing regret that the bulk of the orders went to foreign companies. If, as seems likely, future scanners are allocated on a geographical basis it is very unlikely that Guy's will ever have one—unless money can be found from sources other than the R.A.W.P.—conscious mandarins of the Department of Health. We already share the brain scanner at the Maudsley, an arrangement that has its problems. It appears as if this new advance has overtaken us at Guy's with barely a missed-beat of excitement in the collective pulse—reason enough for devoting part of the present *Gazette* to the subject.

I shall long remember the comments of one consultant physician at a north-eastern hospital when in the middle of a clinic he received his first

brain scans ordered from the regional centre. He studied them long and hard and then turned to me with a new light in his eye. "My boy, what I would give to be starting in medicine again today. The possibilities . . . the possibilities!"

NEWS IN BRIEF

Dr. W. Jackson

The recent appointment of Dr. W. Jackson as Medical Editorial Director of *Medicine* adds another Guy's man to the list of Guy's men holding distinguished editorial positions. Other alumni who are editors include Prof. Alexander Bearn, Editor in Chief, the *American Journal of Medicine,* Dr. Ian Munro at the *Lancet* and Dr. Drummond Rennie with the *New England Journal of Medicine.*

Prof. Bearn is also Editor of the *American Journal of Genetics* and one of the editors of *Beeson and McDermott's Textbook of Medicine.*

We offer Dr. Jackson our warmest congratulations and would be delighted to hear from any other Guy's men and women holding similar positions.

New Area Dental Officer

We would like to offer our congratulations to Mr. G. L. Standring on having been appointed Area Dental Officer for Greenwich and Bexley Area Health Authority. We wish him all the best for the future.

New Appointment at the University of Texas

Our warmest congratulations go to Huw F. Thomas, who qualified in 1975, on his appointment as assistant professor in the Department of Pediatric Dentistry at the University of Texas at San Antonio. Prior to his appointment Mr. Thomas undertook research at the Eastman Dental Centre at Rochester.

Dates from the Medical Diary

Friday, 29th July—Schedules for the Final Conjoint Examination in September must be left in the Medical School Office not later than this date.

Tuesday, 1st August—Entries close for Final M.B., B.S. (Old Regulations) Examinations.

Tuesday, 8th August—Entries close for Preliminary Examination for Studies in Medical Subjects.

Friday, 25th August—Entry forms for M.B., B.S. (Revised Regulations) Examinations in November must be left in the Medical School Office not later than this date.

Monday, 28th August—BANK HOLIDAY—Medical School Office closed.

Monday, 18th Sepember—Preliminary Examination for Studies in Medical Subjects begins.

Monday, 25th September—Final Conjoint Examination begins.

Friday, 29th September—Entries close for the M.B., B.S. (Revised Regulations) Examinations in November

Dates from the Dental Diary

Monday, 31st July—Applications close for the Final L.D.S. Examination, Part II (Dental Prosthetics).

Monday, 7th August—Applications close for the Final L.D.S. Examination, Parts I and III.

Tuesday, 8th August—Entries close for Preliminary Examination for Studies in Medical Subjects.

Monday, 14th August—Applications for the First L.D.S. Examination (obtainable from the Medical School Office) must be left in the Medical School Office not later than this date.

Friday, 18th August—Entries close for the Final Year Prize Examination.

Monday, 28th August—BANK HOLIDAY—Medical School Office closed.

Wednesday, 30th August - Thursday, 31st August—STUDENTS BEGINNING THE CLINICAL PERIOD OF STUDY COMMENCE WORK.

Friday, 8th September—Applications for the Third B.D.S. Examination, Parts I, II, III, IV and V (obtainable from the Medical School Office) must be left in the Medical School Office not later than this date.

Monday, 11th September—Written Papers for Final Year Prize—this week.

Monday, 11th September—Final L.D.S. Examination, Part II (Dental Prosthetics) begin.
Applications close for the First L.D.S. Examination.

Monday, 18th September—N.B.—The Preliminary Examination for Studies in Medical Subject will begin this week.

Tuesday, 19th September—Final L.D.S. Examination, Part I begins.

Monday, 25th September—Entries close for the Prize in Children's Dentistry, including Orthodontics.

Thursday, 28th September—Final L.D.S. Examination Part III begins.

Prizewinners

Dermatology Firm Prize
1st Prize: M. Cooper.
2nd Prize: So N K-Y.

Guy's/St. Thomas's Historical Essay Prize 1978
Prize: T. J. Houlding.
Proxime Accessit: P D. Kapff

Golding-Bird Medal and Prize in Obstetrics and Gynaecology
Medal and Prize—Miss H. M. Cotton.
Certificate—J. C. McArthur.

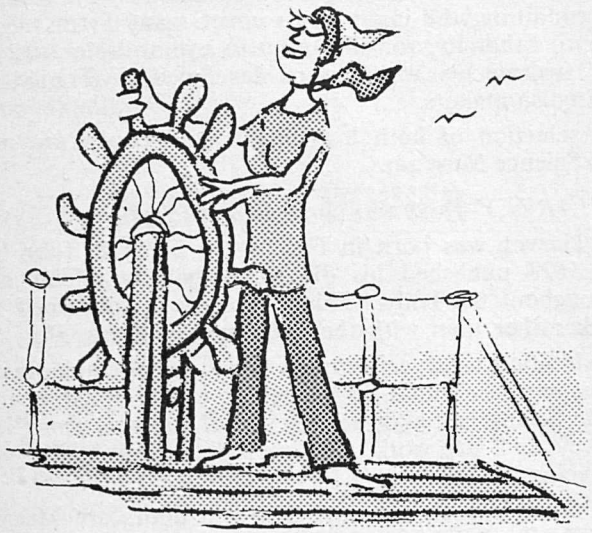
I.C.I. Pharmaceuticals Division Prize in Therapeutics and Clinical Pharmacology
P F. Shipton.

Treasurers Medal and Tewfik Prize in Surgery
Miss Stephanie A. Amiel.

Larkin Prize in Surgery
No award.

The Pearl Girl Endowment Policy

with options on marriage



The PEARL GIRL policy is specially designed for the young lady who expects that one day she will marry (it also provides attractive benefits should she remain single).

Face the future with confidence

SEND TODAY FOR OUR INFORMATIVE LEAFLET

PEARL ASSURANCE COMPANY LIMITED

Chief Office: High Holborn, London, WC1V 7EB

Cover yourself with Pearl assurance

Exhibitions at The Science Museum

WELLCOME MUSEUM—recent acquisitions

The Wellcome Trustees and the Science Museum recently joined forces to acquire an important collection of surgical instruments, instrument catalogues and treatises on surgery.

Purchased at auction in Paris on 7th February 1978, these items formed part of the collection belonging to the Parisian surgical instrument makers Collin-Gentile. Through the generosity of the Wellcome Trustees about a third of the surgical instruments were acquired for the Museum at a cost of over £12,000. These constitute an important well-documented collection of instruments, representative of the periods spanned by the several companies. In excellent condition, the instruments cover many forms of surgery, from hysterectomy to lithotrity, tonsillectomy to eye and ear surgery. Many are variations of instruments which were developed in France but were not supplied by English makers.

A small selection of both instruments and books are now on public display in the Science Museum.

WILLIAM HARVEY—and the circulation of the blood.

William Harvey was born in Folkestone in 1578, four hundred years ago, and in 1628 published his discovery that the blood circulates continuously throughout the body. This exhibition is concerned with Harvey's scientific work rather than with the daily events of his life.

In the exhibition are specimens of blood vessels and organs illustrating his discoveries, together with a large working model of the heart. The Royal College of Physicians has allowed the use of extracts from its well-known film on Harvey and his work, and these bring alive the motion of the valves in the veins.

The exhibition is open now and Museum hours are Monday - Saturday 10.00 - 18.00 and Sunday 14.30 - 18.00. Any enquiries should be referred to the Press and Information Officer, Miss E. St. John Smith (01-589 3456, Ext. 632).

Appreciation

DR. F. L. INGRAM

Doctor Ingram was born on 22nd May 1913 and entered the Dental School at Guy's in 1931. He qualified as a dental surgeon, passing the L.D.S. in 1936 and went on to a medical qualification taking the Conjoint in 1940. He was Mr. Doubleday's House Surgeon in 1936 and also House Officer in Emergency Medical Service in 1940, entering the Royal Army Medical Corps later that year.

His interest in dental radiography was stimulated by Dr. "Jimmy" Worth and in 1946 he obtained the

D.M.R.D. He filled a number of radiology appointments and in 1950 was appointed Radiologist to Canterbury Hospital and the Eastman Dental Hospital. In 1956 he was appointed Consultant Radiologist to Guy's Dental School.

Frank has a kind considerate personality always very approachable and pleased to impart his profound knowledge to both students and dental surgeons. A superb interpreter of a dental radiograph he was seldom, if ever, known to make an error and for the hundreds of thousands of radiographs upon which he reported this is surely a remarkable record.

He married Mary, his dear wife, is a happy father of four children and has several grandchildren. He is devoted to his family. His beautiful garden at Barham must be seen to be believed and he plans to devote much of his retirement to making it more beautiful. We wish Frank and Mary many years of happiness and leisure time together enjoying their family and their lovely garden. He will be much missed at Guy's and we hope he will come and see us sometimes.

M. M.

BIENNIAL DINNER

Enquiries:

Telephone

01–407 7600—ext. 3378 up to 22.9.78

01–777 7756—25.9.78–6.10.78

The next **BIENNIAL DINNER** will be held at The Connaught Rooms, Great Queen Street, London, W.C.2 on FRIDAY, 6th October, 1978 at 7 p.m. for 7.30 pm and I hope that it will be possible for you to attend.

Mr. Kenneth Hooper, F.D.S., R.C.S.,Eng., has kindly agreed to act as Chairman.

We are sending this circular to qualified Guy's men and women, medical and dental, who have supported the Dinner in recent years. There may be others known to you who have not attended a previous Biennial Dinner, in which case I should be grateful if you would draw their attention to the date of this function.

We regret it is not possible to invite guests who are not qualified Guy's men or women, but the number of Guy's medicals and dentals including present qualified staff who may wish to attend is unlimited.

Every effort will be made to place you as near to your contemporaries as possible, **PROVIDED WE RECEIVE APPLICATIONS IN GOOD TIME**, and I shall be glad if you will state on the attached form for tickets the names of friends near whom you would like to sit. Please note the closing date is Friday, 22nd September, 1978.

A **CLINICAL MEETING HAS BEEN ARRANGED FOR THE AFTERNOON**. Dr. Maisey of the Department of Nuclear Medicine will be presenting "Modern applications of Nuclear Medicine" in the lecture theatre on the 30th floor of the new Tower Block at 2.15 p.m. If you are proposing to attend this meeting please indicate with a tick in the box overleaf.

It is advisable to order Wines before going into dinner.

Please reserve a seat for me at the forthcoming BIENNIAL DINNER. I hope to bring ..... guests (qualified Guy's men and women only), whose names are:—

.....

.....

I enclose cheque for £..... being £9.00 (nine pounds) for each ticket required made payable to **"GUY'S HOSPITAL BIENNIAL DINNER".**

Name ..... Medical/Dental

Address .....

Year of Qualification ..... Signed .....

Please state the names of some of your friends near whom you would like to sit:

.....

.....

Will you please return this form together with cheque, AS SOON AS POSSIBLE and not later than Friday, 22nd September, 1978 as we must have adequate time to prepare the seating arrangements and to give the printers the complete list of names of acceptances.

I/We will be attending the Clinical Meeting at 2.15 p.m. ☐

F. N. GLOVER,
Honorary Secretary.
Biennial Dinner.

Special feature

COMPUTERISED TOMOGRAPHY

A brief history of computerised tomography

Computerised tomography (CT)—the rapid production of cross-sectional X-ray pictures by brain and body scanners—has a short but meteoric history barely spanning the last decade. Although one might class CT as a "technological breakthrough" it really represents a more efficient use of existing technologies. By the linking together of the tomographic X-ray machine and a computer a wealth of previously unassimilable information can be collected and synthesised into pictures of the body's interior.

This fertile marriage of technologies was first envisaged by Godfrey Hounsfield, F.R.S., a senior research engineer at the Central Research Laboratories of the E.M.I. company, whose interest was in pattern recognition by computers. In 1967 Hounsfield was working to find ways of programming computers to recognise the written word, and to store and accurately display

written information. In the course of this work Hounsfield was struck by the waste of useful clinical information in conventional radiographs. In a normal X-ray examination the patient is placed between the source of radiation and the radiosensitive film and a shadow picture is made of the patients tissues, which have a spectrum of density and therefore variable absorption and transmission of X-rays. One obvious problem with this system is that dense tissues such as bone may obscure important details of underlying tissues of lower density. Hounsfield estimated that only 1% of information could be usefully interpreted.

Hounsfield decided to repeat this process at different angles and fed the information into a computer programmed to assemble and display it, using radiosensitive detectors instead of film. In his initial experiments he mounted perspex and fabric shapes and a pigs head on a rotating lathe bed, through which he passed gamma rays from an isotope source. The system had to be exposed for 9 days and took two and a half hours of computer analysis, but the results were encouraging. With a D.H.S.S. development grant and the agreement for clinical trials a prototype brain scanner was built and installed at Atkinson Morley's Hospital, Wimbledon in September 1971. The E.M.I. brain scanner was launched at a London press conference in April 1972 and the first production model installed in Britain was at the National Hospital for Nervous Diseases in August 1973.

The whole body scanner was announced in 1975 when worldwide annual sales of scanner systems reached £25 million. In the following two years the growth and development of CT reads like a classic success story—by May 1977 over 800 systems had been ordered and more than 600 had been installed in over 30 countries Some three million patient examinations had been undertaken.

At present it would probably be fair to say that the industry has reached a period of reaction after the initial flush of success. E.M.I. is now having to fight seriously to maintain its markets in the face of growing competition from such companies as Ohio Nuclear, General Electric (U.S.A.), Elscint and Siemens, not to mention the Japanese. E.M.I. Medical announced its first losses earlier this year following the downturn in the North American market and costly patent actions against American rivals.

On the clinical side there have been professional criticisms of the American *laissez faire* approach to the buying of scanners and of the lack of research to assess the influence of CT on the outcome of diseases. These rumblings indicate that we, the clinicians, should consolidate the precipitate advances of the past few years and consider our present practices and future plans in the best interests of our patients.

The physical basis of CT Scanning

Professor S. J. Wyard
Department of Physics, Guy's Hospital

Röntgen discovered X-rays in 1895, recognised immediately their value as a diagnostic aid in medicine, and took a radiograph of his wife's hand a few months later which would bear comparison with a present-day radiograph.

The method used by Röntgen, which is no doubt familiar to most readers of the *Gazette,* was to send a broad beam of X-rays through the part

of the body to be radiographed and to record the transmitted intensities on a photographic plate. This gives a picture in which any objects in the path of the beam which are opaque to X-rays are shown up by the shadows they cast on the plate.

There are two major drawbacks to this system, (1) since all objects in the path of the X-ray beam are shown super-imposed, the radiograph can be rather confusing, (2) although bones and metallic objects show up clearly, the contrast available is inadequate, on the whole, to differentiate between soft tissues. The fact that Röntgen's method has been used up to the present day with evident success is due (i) to the enormous skill of the human eye and brain, especially when trained by experience, in picking out the essential information for a picture and ignoring the rest, (ii) the development of methods of increasing contrast by introducing into soft tissues materials which are opaque to X-rays; but these methods can be painful and, on occasions, hazardous.

Computerised tomography* (CT) is a new approach, in which the main innovation is the use of a computer to sort out the effects of the various overlapping objects in the human body through which the X-rays pass. The first, and most successful, commercial application was developed by Hounsfield (1973) and the following description is based on the E.M.I. Mark 1 scanner, designed for radiography of the head.

A *narrow* beam of X-rays passes through the patient's head and the transmitted intensity is recorded, not by a photographic plate, but by a scintillation detector; a device which gives an electrical signal proportional to the strength of the X-ray beam. The reading of the detector is fed to a computer and stored there. The whole assembly of X-ray tube and detector scans backwards and forwards across the head, taking 240 readings of transmission as it does so (Figure 1).

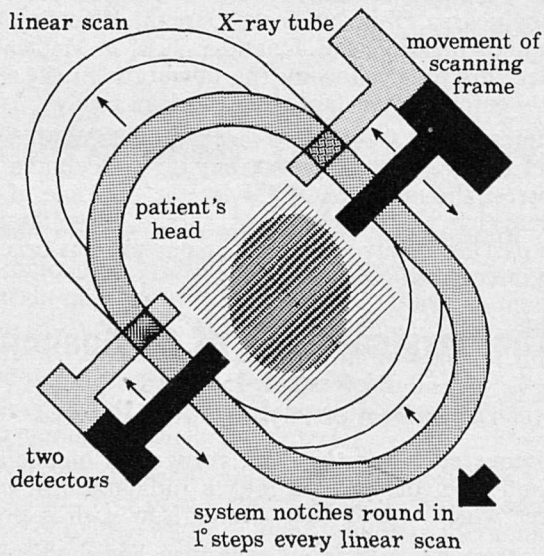


Fig. 1.

*Tomography from Greek αομοο-, a cut or slice.

This is illustrated as scan 1 on the scanning sequence diagram (Figure 2). At the end of the scan, the scanning system is rotated 1°, and the process is repeated as shown in scans 2 and 3 rotation exaggerated in the diagram (for the scale of clarity). This procedure continues for 180 scans, when 43,200 readings will have been taken by the detector in order to produce a picture of one single slice of the head.

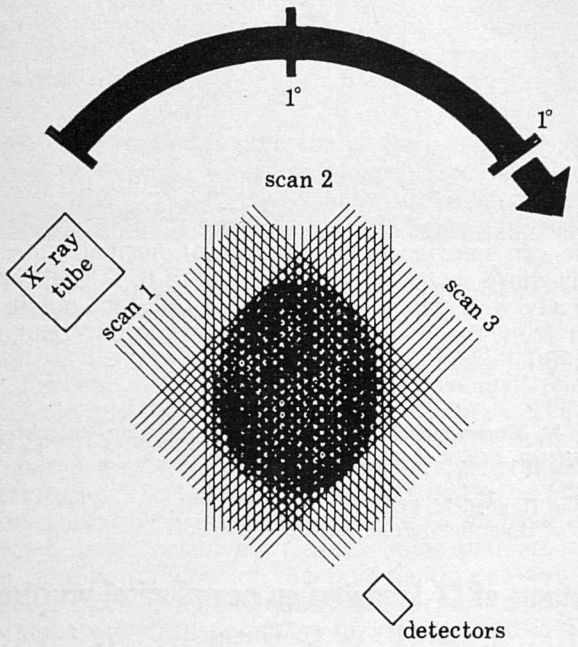


Fig. 2.

The computer now gets to work on this mass of information, and assuming that the slice of the head is divided up into a giant chess board of 160 x 160 squares, each with sides of just over 1 mm, calculates the absorption of each one separately. The absorption values can be printed out numerically, displaying all the information available, though this is not very easy to interpret. Alternatively the information may be displayed as a picture in a form which is more familiar to the radiologist, but which omits some of the information.

While the computer is working out the figures for one slice, the X-ray tube and detector move down and take the measurements for the next slice. In this way the whole brain is scanned in about half an hour. The skin dose to the patient is about 2R, comparable with that from conventional radiography.

The above description is based on the E.M.I. Mark 1 scanner, but development of the technique has been rapid, and a machine has already appeared for scanning the body, in which the time to scan a single slice has been reduced from 4 minutes to 20 seconds.

What are the advantages of CT Scanning compared to conventional radiography? There are several, and with a technique still very much in its infancy it is not possible to predict which will turn out to be the most im-

portant. The system is extremely flexible, and can be designed and adjusted so as to extract the maximum amount of information possible for the investigation in hand and then to present it in the most useful form. For example, the *contrast* in the print-out picture can be increased at will until differences in soft tissue are clearly visible. Increases in contrast are limited not by the system, but by the need to limit the patient's exposure to X-rays.

In the early machines, the spatial resolution was less good than in conventional radiography, giving a somewhat coarse appearance to the pictures. There is no reason, however, why the resolution should not be increased to meet any requirements, provided that the scan is restricted to localised areas of specific interest.

To a physicist one of the most interesting features of the system is that for the first time it presents absolute values of X-ray absorption for individual pieces of tissue as in the numerical print out. Although not much clinical use has been made of these numbers so far, perhaps because of their novelty, one can imagine a future atlas of normal values of X-ray absorption, and diagnosis made by comparison with it. It is also possible, by scanning successively with two X-ray beams of different quality, and subtracting one scan from the other to obtain information about the atomic number of the material under scan.

References

HOUNSFIELD, G. N. Computerised transverse axial scanning (tomography) Part I. Description of system. Brit. J. Radiol., 1973, **46**, 1016–1022.

Figures

Figure 1 is Figure 4 of Hounsfield, Proc. Roy Soc., **195**, 281.
Figure 2 is Figure 5 of Hounsfield, Proc. Roy Soc., **195**, 281.

The impact of CT Scanning on neurological practice

Dr. R. A. C. Hughes

Department of Neurology, Guy's Hospital

By April 7th 1978 when the Lord Mayor of London officially "opened" the E.M.I. advanced head scanner in the neurological unit at the Maudsley Hospital our neurological practice had already been dramatically altered. Since April 1977 nearly three thousand scans have been performed. Other neuroradiological investigations of the intracranial contents have dwindled, and air encephalography has almost completely disappeared. The benefits of this machine are felt alike by patient, clinician and, despite its cost, by the exchequer.

For the patient a computerised axial tomographic scan is merely a special "X-ray" of the head which involves a single outpatient visit lasting up to an hour. He or she merely has to lie still on a bed with his or her head in a box during the four and a half minute sweep of the armature carrying the twin X-ray tubes and detectors. This process is usually repeated three times. Many patients have a second set of pictures taken following "enhancement" by the intravenous injection of an iodine containing contrast medium to show the vascularity of some lesions. The only risk of the procedure is an allergic reaction to the iodine. In the few uncooperative patients sedation or general anaesthesia are necessary. The computer derives horizontal sections of the skull, brain, subarachnoid space and ventricles which are amazingly clear and simple to understand (Fig. 1). Air encephalography,

a. b.

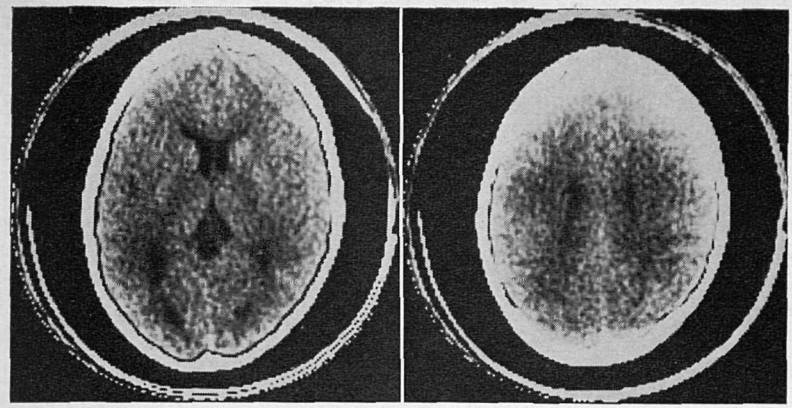


Fig. 1. Normal Scan.

(a) (b) Normal lateral ventricles and normal tissue density in the cerebral hemispheres.

the most satisfactory previous technique for outlining the ventricles, involved the removal of 20-30ml of cerebrospinal fluid and injection of air through a needle into the lumbar subarachnoid space. The patient had to be tilted into extraordinary positions to outline all portions of the ventricles. The investigation was usually performed under general anaesthesia because it was so unpleasant. To the anaesthetic risks had to be added the hazard of deterioration caused by pressure changes inside the head in the presence of an unsuspected space occupying lesions. Some patients with dementia became more confused following the investigation. Many patients suffered from headache which confined them to bed for several days. If patients were allowed to make informed decisions, they would vote every time for more and more CT scanners and the abolition of air encephalography wherever it is practised. The advent of CT scanning has also reduced the need for vertebral and carotid arteriography. These are performed by the injection of contrast medium via a needle stuck directly into the vertebral or carotid artery or via a catheter from the femoral artery. They are also usually performed under anaesthesia. They are difficult procedures and carry not only the anaesthetic risk but also the slight risk of dislodging atheroma and causing cerebral or brain stem infarction which may rarely be fatal. For the patient the procedure of a radioisotope scan of the head is not unlike CT scanning. The disadvantage of the radioisotope scan is that it does not show the ventricles, misses more lesions than the CT scan and gives less information about the type of lesion.

For the neurologist the CT scan has offered a major advance in the visualisation of most types of intracranial pathology. The patient with dementia can now be investigated non-invasively as an outpatient, when in many cases the presence of cerebral atrophy (Fig. 2) will be confirmed by the demonstration of dilated ventricles and cerebral sulci. In a few patients a treatable cause, such as meningioma or a subdural haematoma, may be found. Unless there is some special reason, there is now no need, as far as investigation is concerned, to admit the demented patient to hospital. We have yet to divest ourselves and our patients of the ritual belief that thorough investigation necessarily means hospital admission.

a. b.

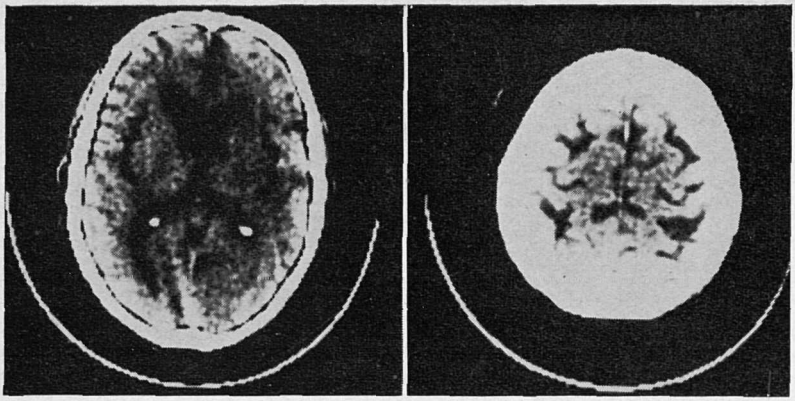


Fig. 2. Cerebral Atrophy.

(a) Large lateral ventricles and sylvian fissures. The choroid plexuses are calcified and visible in the trigones of the lateral ventricles.

(b) Very wide sulci on the upper surfaces of the cerebral hemispheres.

Similarly people with late-onset focal epilepsy can have a single out-patient CT scan instead of running the gauntlet of a radioisotope scan arteriogram and sometimes air encephalogram which used to be required. If the outcome of the CT scan is the demonstration of a meningioma (Figure 3) there is no difficulty about explaining to the patient the need for the

a. b.

Fig. 3. Left temporo-parietal meningioma.

(a) There is a mass with high attenuation which has burrowed into the cerebral hemisphere. The trigone of the left lateral ventricle is compressed and the calcified choroid plexus is displaced forwards. The high attenuation indicates the presence of small amounts of calcium in the tumour—too small to be seen on a conventional radiograph.

(b) Scan made following the injection of Sodium Iothalamate which enhances the image of the tumour, showing its exact size. The molecules of contrast medium pass the blood-tissue barrier and accumulate in the intercellular spaces of the tumour.

neurosurgical removal of a "benign tumour". If a malignant tumour is found (Fig. 4) the CT scan has presented us the problem of how to explain to the patient and his relatives the seriousness of the condition which they had probably not been suspecting. The old-fashioned sequence of investigations was a two-edged sword: it kept the patient and doctor in suspense and it warned the patient and his family that "Something is rotten in the State of Denmark".

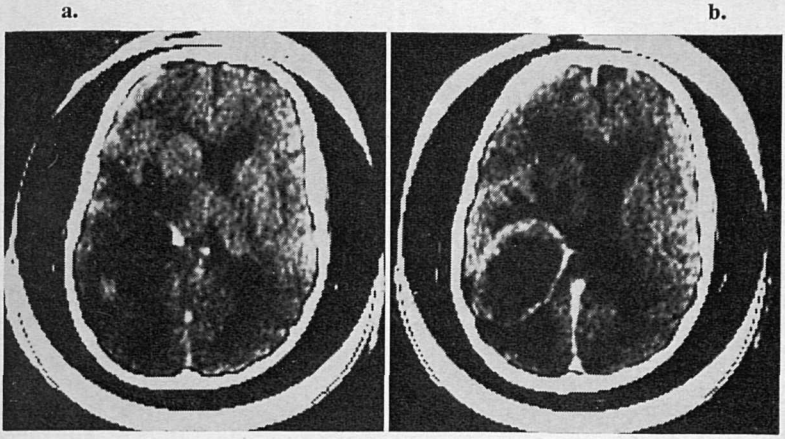


Fig. 4. Glioma

(a) The large area of abnormal attenuation in the left parietal lobe is caused by tumour and surrounding oedema.

(b) Scan made following intravenous injection of Sodium Iothalamate (Conray 420). There is accumulation of contrast medium in the margins of the tumour (ring enhancement). The enclosed area is necrotic tissue. The low attenuation "fingers" anterior to the tumour are characteristic of cerebral oedema. The straight sinus is visible because the blood within it contains contrast medium.

In neurological and neurosurgical emergencies the advantages of the CT scan are self-evident. Following head injury, extradural, subdural and intracerebral haematomas can readily be demonstrated, although the abrupt rise of intracranial pressure with an extradural haematoma may demand immediate operation without moving the patient. In subarachnoid haemorrhage the site of bleeding is often visible and large berry aneurysms or arteriovenous malformations can be demonstrated following enhancement with intravenous contrast medium. In stroke the CT scan helps to differentiate infarction from haemorrhage (Fig. 5), a differential diagnosis which is surprisingly difficult and inaccurate with clinical criteria alone.

These common examples from the wide range of uses in the CT Scanner should leave no doubt about its vast benefit to patient and doctor. The capital cost of installation and recurrent expenditure for running the machine are high but it has been forcefully argued that these costs are more than offset by the reduction in other investigations and duration of hospital stay (Thomson 1977).

Our CT scan was at least a second generation model when it was installed and the neurological and radiological worlds buzz with news of

a. b.

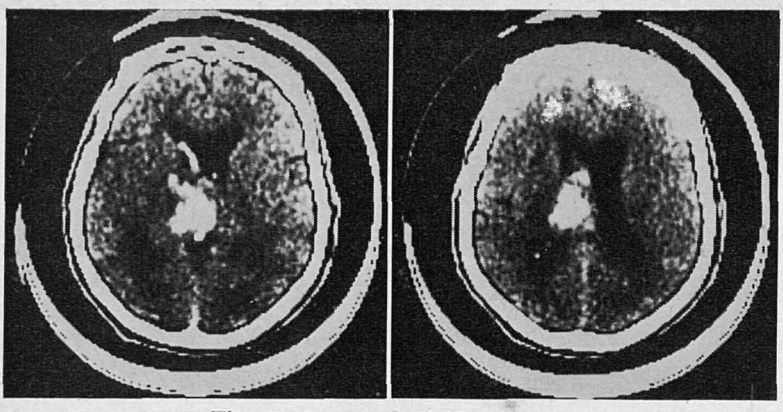


Fig. 5. Intracerebral Haematoma.

(a) (b) The irregular area of high attenuation (white) is clotted blood in the left thalamus and left lateral ventricle. Infarction normally produces a low attenuation area but the scan may be normal in the early stages.

newer and better machines. With a general purpose scanner it will also be possible to scan the spinal canal and perhaps avoid some of the need for myelography or radiculography. It is certainly the only satisfactory technique for demonstrating lesions affecting the lumbosacral plexus. The full impact of CT scanning on neurological practice will not be felt at Guy's until we have headscanning facilities on the Guy's site. Two classes of patients would benefit most—those in coma who are too ill to make the two mile ambulance journey to the Maudsley Hospital for their scan and those with stroke. If we are to attempt to prevent the progression of stroke in its early stages we need to know whether it is due to infarcation or haemorrhage and a CT scan is a very powerful technique for making this distinction. At a time when there were only half a dozen E.M.I. scanners in the whole of Great Britain an American medical student commented on a round that her medical school's hospital alone had three. It is inconceivable that an impoverished health service or bankrupt Area will provide a CT scanner for the Guy's site in the forseeable future but we and our patients need one very badly. Please tell your rich friends!

Acknowledgement

I would like to thank Dr. R. D. Hoare, Director of the neuroradiology departments at Guy's and the Maudsley Hospitals, for providing the illustrations and their captions.

Reference

THOMSON, J. L. G. 1977. Health Trends, 1, 16. Cost effectiveness of an E.M.I. Brain Scanner: a review of a two year experience.

The Whole-Body Scanner in Clinical Practice

Jan de Winter

Director, Charles Hunnisett Department of Computerised Tomology*
Senior Consultant in Radiotherapy and Oncology

Royal Sussex County Hospital
Visiting Senior Fellow, University of Sussex

Although still only in its infancy as a clinical tool, the whole-body scanner (Fig. 1) has already had a multidisciplinary impact in medicine.

First and foremost it has transformed the approach to neurological investigations by decimating the need for invasive examinations such as air-encephalography and selective angiography and by putting an end to key-hole surgery. On account of its accuracy in the brain CT is now used as the initial screening method to detect, confirm or exclude the presence of a suspected intracranial lesion; in other words, because of its simplicity, reliability and acceptability, this examination has become, to coin a phrase, "the chest X-ray of the brain". Nothing remotely comparable to its pre-eminence in neuroradiology has been achieved by the scanner elsewhere in the body and for this reason the scanner, as a rule, is not used as a screening tool anywhere but in the brain.

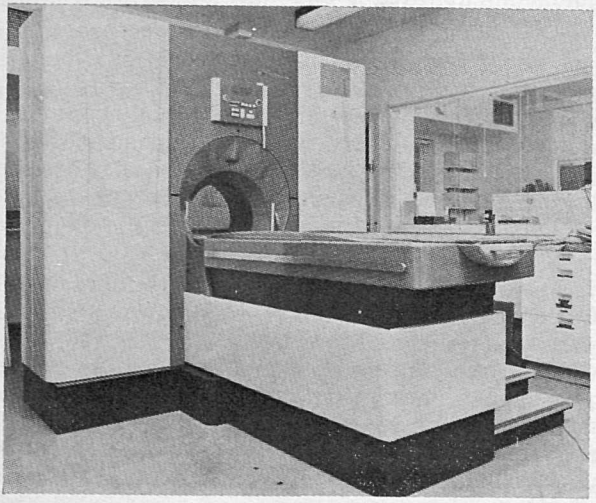


Fig. 1.

EMI CT 5005 Whole-Body Scanner at the Charles Hunnisett Department of Computerised Tomology, Royal Sussex County Hospital, Brighton. The picture shows the scanning unit, which houses the rotating X-ray tube and detector array, located diametrically opposite each other on the scanning frame. The picture also shows the patient table which may be electronically driven to transport the patient through the scanning tunnel.

*The world's first radiation-oncology dedicated whole-body scanner was donated to the Royal Sussex County Hospital in 1976, as a result of an outstanding act of imaginative philanthropy of Mr. Charles Hunnisett, the prominent Brighton industrialist and benefactor. On the author's advice, Mr. Hunnisett stipulated that the scanner was to be used mainly for the management of patients with cancer, i.e. for the detection of malignant tumours and as an aid to radiotherapy planning. For this reason the scanner was installed adjacent to the existing Radiotherapy Department in the newly erected, purpose-built Charles Hunnisett Department of Computerised Tomology. Tomology is a new term coined to extend the meaning of tomography to include the study and science of body sections, which is the *raison d'être* of the new Department.

Yet the achievements of extracranial whole-body computed tomography (CT), although of less dramatic impact than brain scanning, are not inconsiderable:

(1) CT has revolutionised radio diagnostic procedures in the abdomen and pelvis by visually displaying the parenchyma of hitherto mute subdiaphragmatic organs and by lighting up the obscure retroperitoneal space and the ilio-pelvic lymphnode areas.

(2) It has stamped its mark on radiotherapy-planning and has introduced a new parameter into cancer treatment by facilitating visual monitoring of tumour regression.

(3) It has simplified the teaching and understanding of topographical anatomy by clearly displaying the spatial relationship of organs in the hitherto invisible third dimension.

(4) By its highly acceptable total non-invasiveness it has saved patients a great deal of physical discomfort and mental anxiety as well as, on occasions, admission to hospital and a fruitless operation.

Radiotherapy and Oncology

Of all the clinical specialties, the two disciplines to have most benefited from whole-body computed tomography are radiotherapy and oncology.

Radiotherapy, predictably, has gained most because of the whole-body scanner's known capability of producing cross-sectional body images which display on one section a clear picture of the tumour in its spatial relationship to neighbouring organs and to the patient's body contour, as well as on account of providing for the very first time, adequate data for accurate measurement in centimetres, of volume and position of a deep-seated tumour. This information is destined to overcome the currently weakest aspect of radiotherapy-technology and it is in this direction that improved treatment results will be found.

Oncology, again predictably, has gained most because the one outstanding feature of CT above all others is its proven capability to detect the presence of a focal lesion and to determine its size, its shape, its position, its density, its local spread and its dissemination; besides providing information as to displacement, compression, attachment and/or invasion of neighbouring organs and determining whether the tissue planes are preserved or obliterated (a very valuable pre-operative piece of information for the oncological surgeon).

Technical Principles

The technique used for this remarkable new method is perhaps best described as the revolutionary marriage of X-rays and the computer. It was invented by E.M.I.'s Senior Staff Scientist Godfrey Hounsfield and has been hailed as the most significant advance in the field of medical diagnosis since Wilhelm Konrad Röentgen discovered X-rays in 1895.

In practice an X-ray tube with a pencil-thin, fan-shaped, tightly collimated X-ray beam rotates round that portion of the patient which is being examined. An array of highly sensitive scintillation detectors, situated diametrically opposite the tube on the other side of the body, continues to rotate in unison with the X-ray tube so that all the X-ray photons transmitted through the patient are captured and counted by the detectors, thus ensuring maximum dose efficiency. The principle underlying this method,

which is as simple as it is ingenious, is to use the degree of attenuation of an X-ray beam on its passage through the body as a measure of tissue density, since absorption of X-ray photons is known to rise in direct proportion with increase in tissue density and the resulting images are displayed on a television type viewing screen as thin cross-sectional "salami slice" type of images which, because of their thinness, fail to show structures above and below the plane of section and an entire organ is therefore rarely visible on a single section. Areas with high attenuation such as bone or contrast-material appear white; organs, vessels and muscle cross-sections appear in varying shades of grey; the surrounding low attenuation fat and air appear black.

At the moment CT cannot produce a picture with sufficient tissue-specific characteristics for a tissue diagnosis; therefore scanning cannot as yet be used as a substitute for histology.

Selection of Cases

The two main criteria governing selection of patients for extracranial diagnostic CT are 1. the scanner's proven potential for accurate diagnosis in special anatomical sites such as the upper abdomen or pelvis, and 2. the special capability of CT to consistently demonstrate certain pathological conditions such as tumours, enlarged lymph nodes and secondary deposits. However, being a time-consuming, costly and technologically complex procedure, CT is employed only after all other more simple, non-invasive investigations have proved unavailing.

CT and Ultrasound

When discussing more simple, alternative investigations, it is important to define the relative place of CT to ultrasound, since CT produces images of thin slices of the patient comparable to those of ultrasound. Each system employs a different form of energy and the physical characteristics measured by each are totally different; these differences determine their relative roles and also dictate their limitations. Capital outlay and running costs of CT scanners are about ten times those of ultrasound equipment and the daily patient throughput of a CT unit is about one-third of that of an ultrasound machine.

There is a large area of overlap between these two modalities. CT and ultrasound are complementary as regards patient-size in that CT is most accurate in obese patients whereas lack of fat is an advantage in ultrasound. Taken in conjunction with the established fact that demand of CT will always exceed capacity, it is imperative whenever possible that ultrasound should precede CT, also because frequently optional utilisation of a CT scanner is aided by using ultrasound as a preliminary procedure.

Indications for CT

As already mentioned, extracranial CT is, on the whole, not suitable for use as a screening method in the body. Its diagnostic yield will be highest when employed to answer specific questions such as, for instance, are the para-aortic lymph nodes enlarged, or, is there an adrenal tumour in the suprarenals? Being of superior accuracy and sensitivity to conventional radiography, when used in this way, CT will prove quite invaluable on account of providing information that cannot at present be obtained by any other non-invasive procedure. Some of the pathological conditions, specifically suitable for detection by CT will now be highlighted.

Brain (Figs. 2, 3)

The pre-eminence of CT in demonstrating intracranial lesions remains unchallenged. Both intracranial haemorrhage and cerebral infarcts are clearly demonstrated, as is the presence of primary brain tumours and multiple discrete brain lesions. CT thus provides an instant, painless and reliable method of differentiating a primary brain tumour from a C.V.A. or from secondary deposits, without the need for air-encephalography or a traumatic biopsy (Figs. 2 and 3).

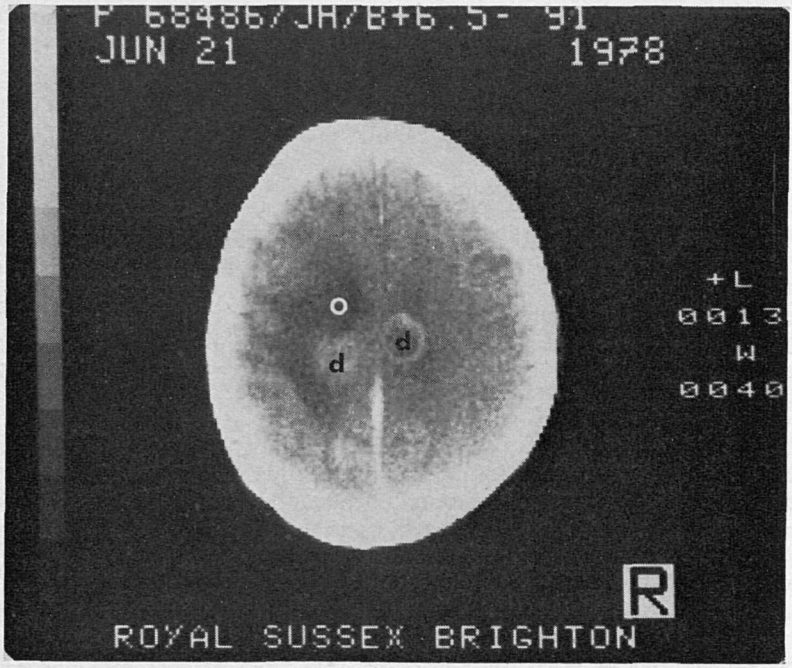


Fig. 2.

Male aged 60. Bilateral secondary deposits (d) in brain from primary carcinoma of lung with contrast enhancement after intravenous injection of Conray and perifocal oedema (o).

Orbits, Antrum and Sinuses (Figs. 4, 5)

The extent of a malignant growth in the orbits, antrum and ethmoids, its relationship to the optic nerve, eyeballs and the degree of bony involvement of antral and orbital walls, can be demonstrated by CT with exceptional clarity, this information being invaluable for subsequent radiotherapy.

Chest (Figs. 6, 7, 8)

The clinical impact of CT has been less dramatic in the lung that it has been in the head or abdomen. This is largely because the conventional chest radiograph is a much more sensitive and accurate examination than similar plain studies of the head and abdomen. However, there are at least three clinical situations where CT provides information which is undetect-

turn to page 296

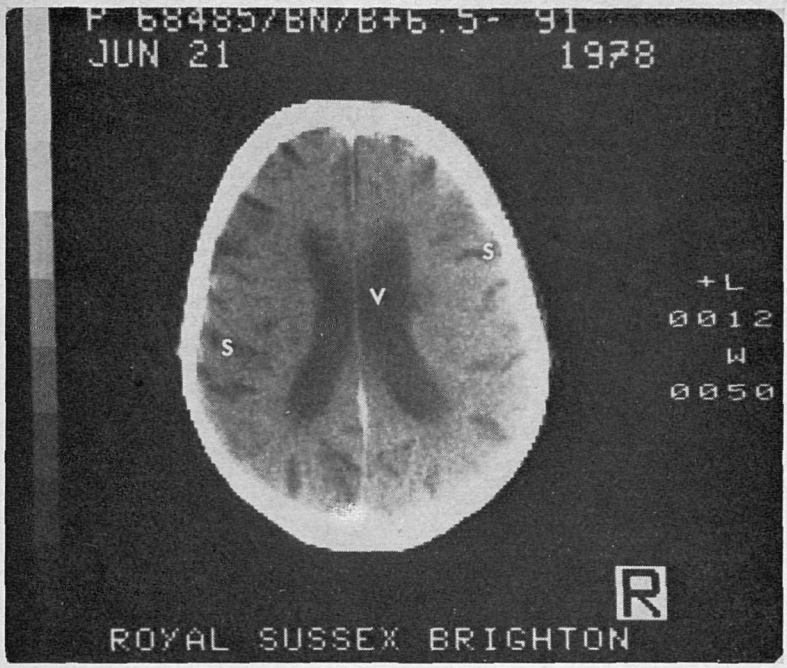


Fig. 3a.
Male aged 78 with dilated ventricles (v) and widened cortical sulci (s) due to cerebral atrophy.

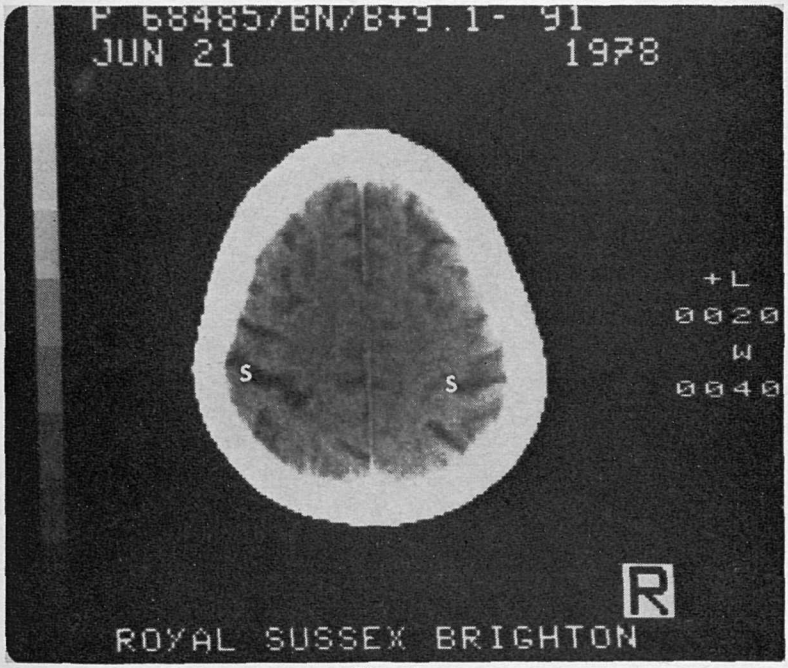


Fig. 3b.
Same patient as Fig. 3a showing gross widening of cortical sulci (s) resulting from brain atrophy.

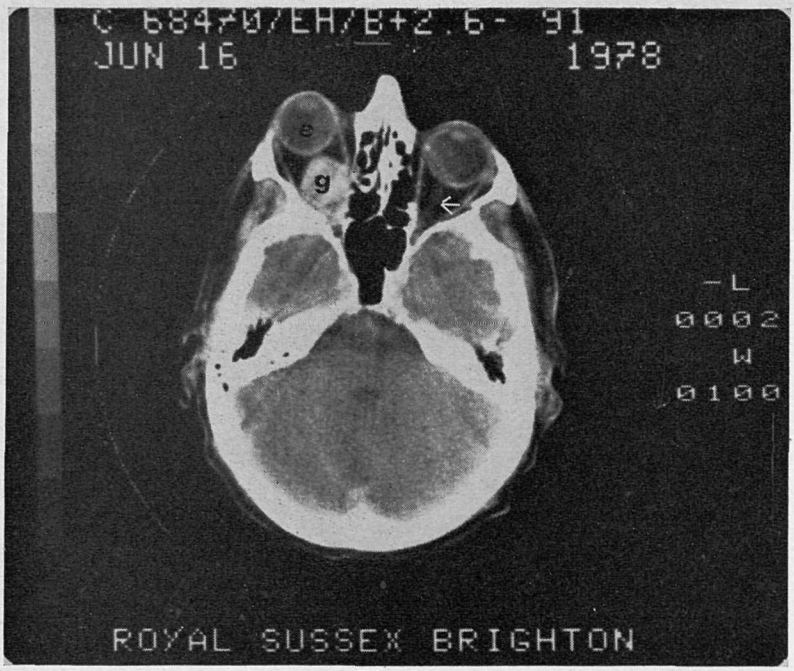


Fig. 4.
Proptosis of left eye (e) due to an optic nerve glioma (g). Normal right optic nerve (arrow).

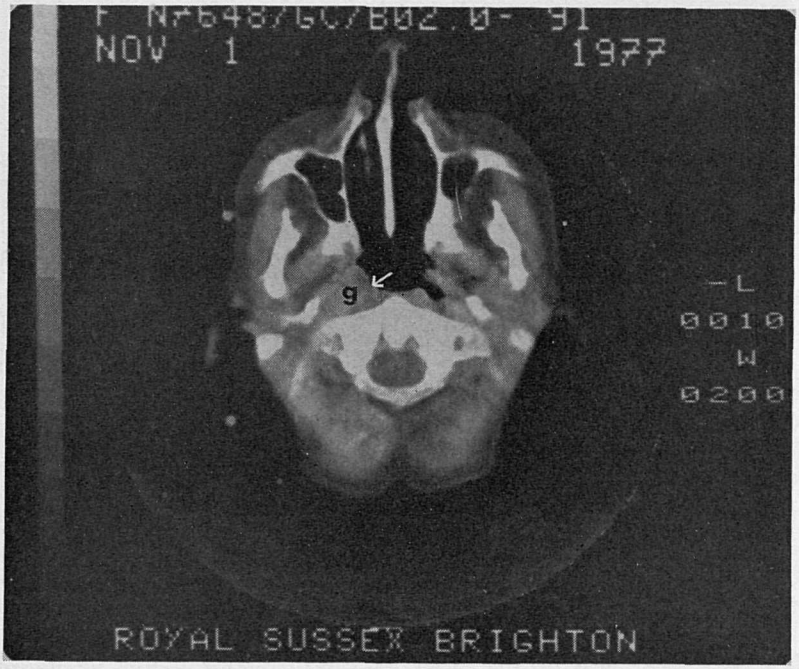


Fig. 5a.
Glomus jugulare (g) tumour obliterating left pharyngeal recess (arrow).

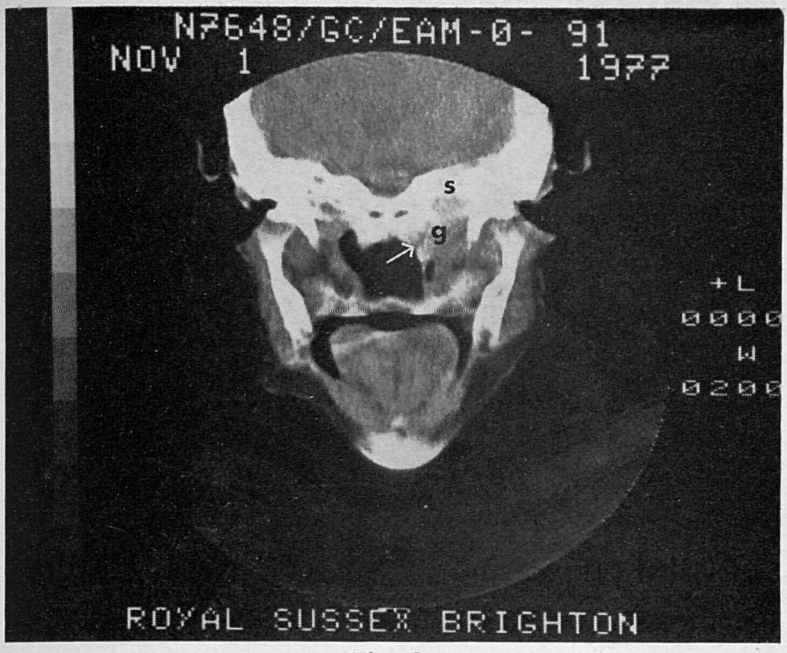


Fig. 5b.

Same patient as Fig. 5a Coronal view. Base of skull (s) eroded by glomus jugulare (g). Pharyngeal recess obliterated (arrow).

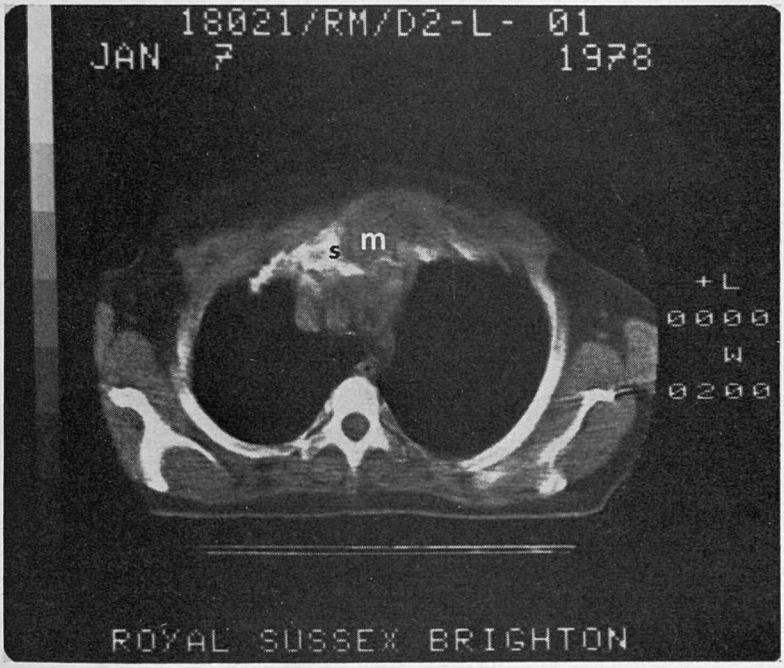


Fig. 6.

Turn over for legend to Fig. 6

Fig. 6. Female aged 40 with primary carcinoma of left breast and erosion of sternum (s) by secondary lymphnode mass (m) arising in the left internal mammary chain. (The sternal erosion was not shown on a conventional radiograph and the enlarged para-sternal lymphnodes were not detectable on clinical examination.)

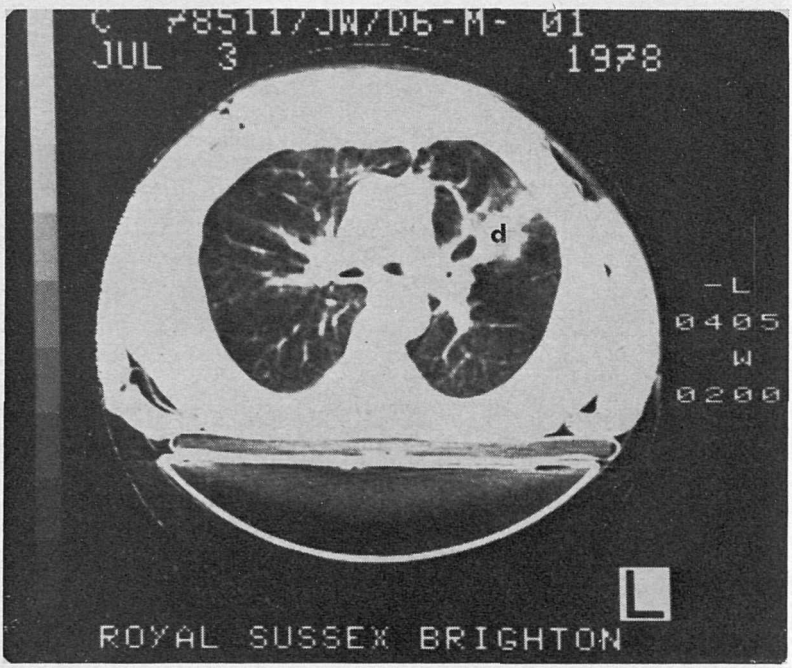


Fig. 7

Secondary deposit (d) in left lung from primary carcinoma oesophagus.

able or poorly seen on conventional radiography or tomography, namely (a) detection of lesions situated in the recesses near the diaphragm posteriorly, particularly in the para-vertebral region, (b) evaluation of the extent of disease in patients with bronchogenic carcinoma by showing additional pulmonary metastases or direct extension of the primary into the mediastinum, or evidence of mediastinal lmyphnode involvement, and (c) finally and probably most important of all, CT provides a more sensitive technique for detecting pulmonary nodules.

The importance of discovering occult nodules in the lung must be put in perspective, however. CT will affect patient management only in cases where a lung tumour is discovered for the first time or where a second malignant nodule is discovered in a patient thought to have only one lesion. In patients known to have two or more lung metastases, periodic monitoring by CT is useful in determining the therapeutic response to cytotoxic chemotherapy.

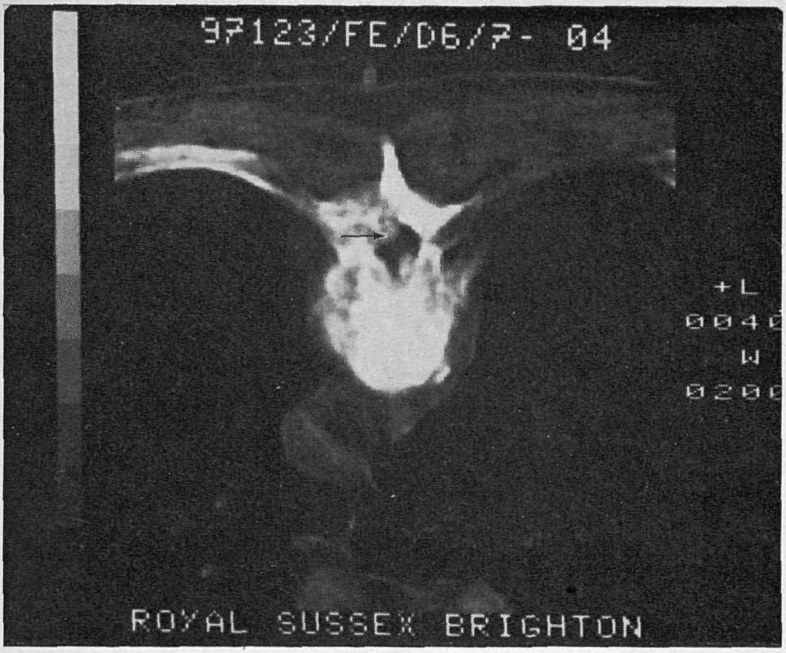


Fig. 8.

Male aged 68 with spinal cord compression. Deposit eroding left lamina and pedicle of D6 from primary carcinoma of prostate. Site of invasion of spinal canal and cord compression (arrow) clearly shown. Patient scanned in prone (=treatment) position.

Abdomen (Figs. 9–14)

The principal clinical usefulness of CT in the abdomen will be found to reside (a) in the diagnosis of primary tumours and cysts (b) in the detection of secondary deposits anywhere but especially in the mesenteric and retroperitoneal lymph node areas, and (c) in the evaluation of total disease involvement.

CT has proved particularly useful in demonstrating tumours, cysts and abscesses in liver, pancreas, spleen, suprarenals and kidneys. However, because of its abundant fat and relatively uncomplicated anatomy the most fruitful area for CT is the retroperitoneal space where abdominal structures are sharply delineated by the extra-peritoneal fat. For this reason CT of the retroperitoneum is an easily performed, accurate and non-invasive method for directly imaging and discovering any one of the following disorders: primary and recurrent tumours, secondary metastatic nodes and lymphomatous lymph node deposits, haemorrhages and perispinal and perinephric abscesses In the case of a suspected retroperitoneal lesion its exclusion is perhaps as important clinically as the detection of a disorder; CT provides an easy and accurate solution to the problem.

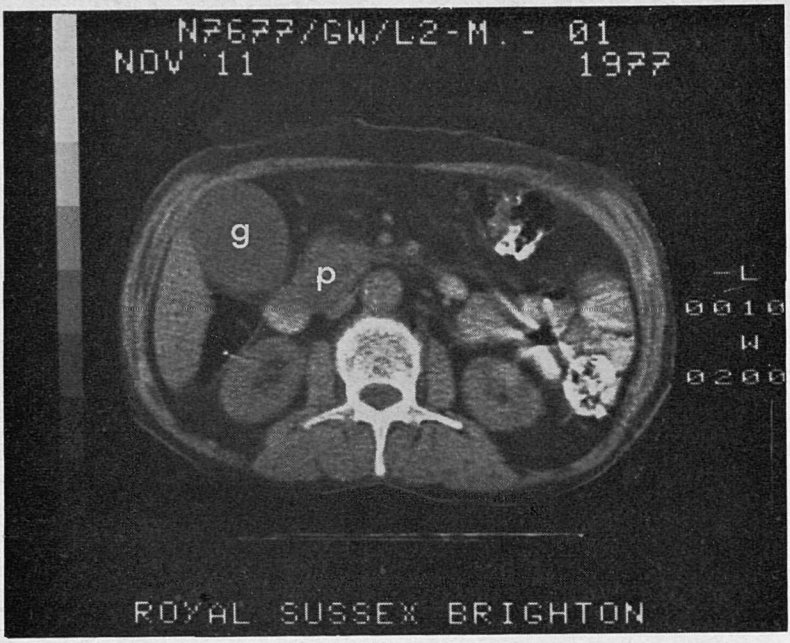


Fig. 9a.

Mass in head of pancreas (p) causing biliary stasis (see Fig. 12) and tense distended gall bladder (g).

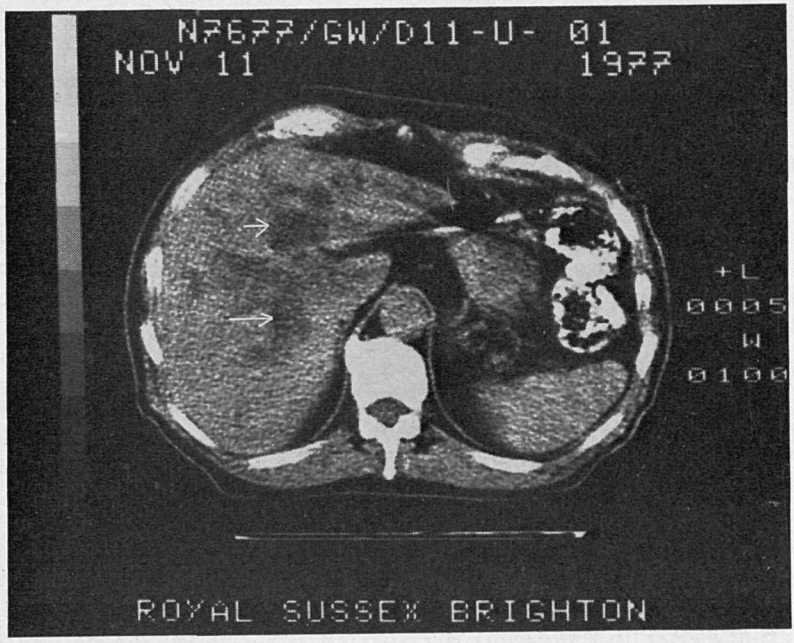


Fig. 9b.

Same patient as Fig. 9a. Cystic spaces (arrows) are dilated ducts caused by biliary obstruction.

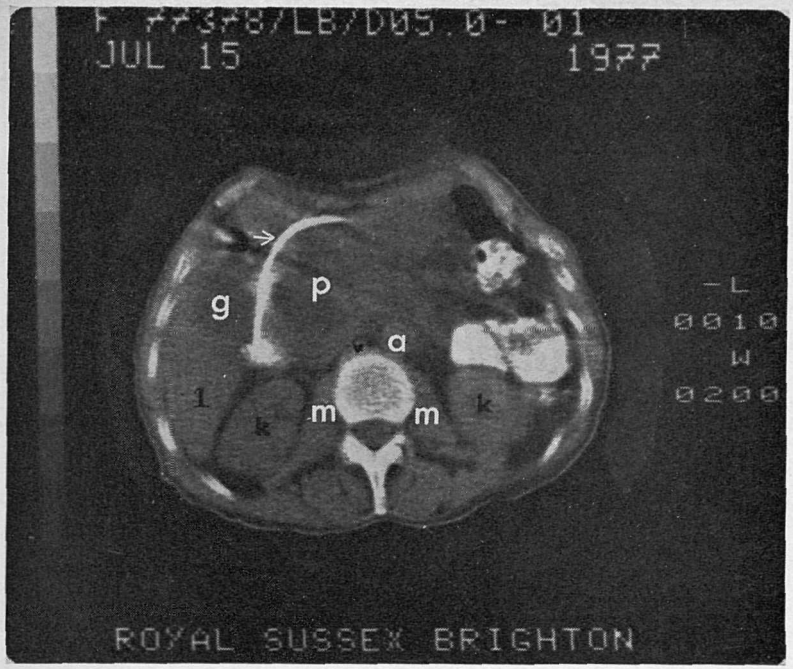


Fig. 10.

Large pseudo-pancreatic cyst (p). Gastrografin-filled duodenal tube (arrow) delineates lateral limits of cyst. Normal aorta (a), inferior vena cava (v), kidneys (k) and psoas muscles (m), liver (l) and tense gall bladder (g) are clearly shown.

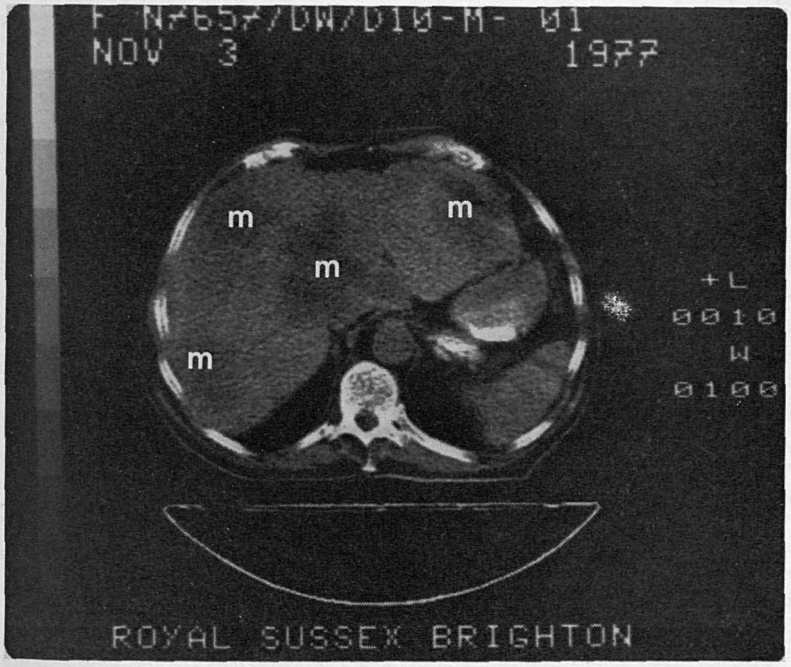


Fig. 11.

Male aged 60 with multiple hepatic matastases (m) from a primary carcinoma of bladder.

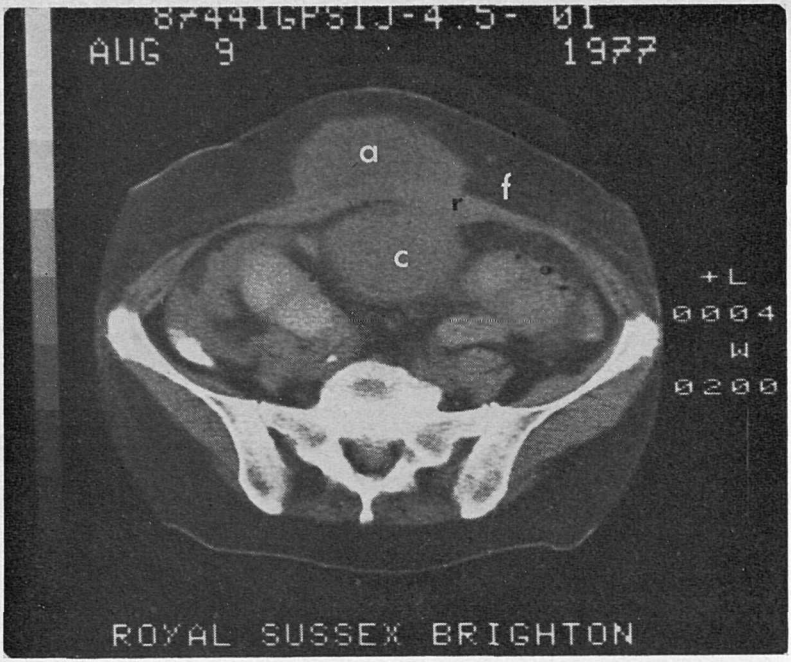


Fig. 12.

Female aged 46 with carcinoma colon (c) and abscess (a) breaking through left rectus abdominis (r) into the abdominal fat (f) (Note difference in attenuation between the denser growth and the more transparent pus.)

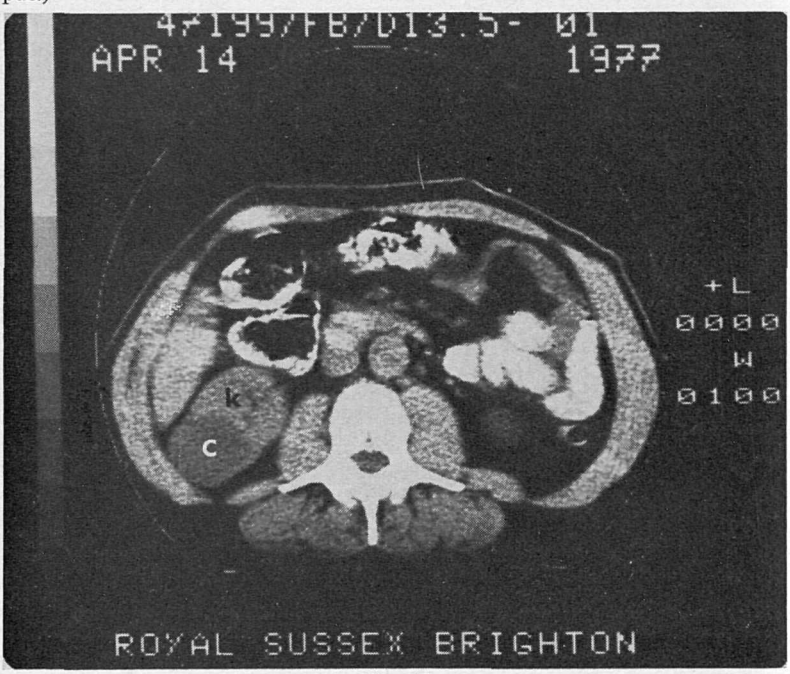


Fig. 13.

Renal cyst (c) occupying postero-lateral part of right kidney (k).

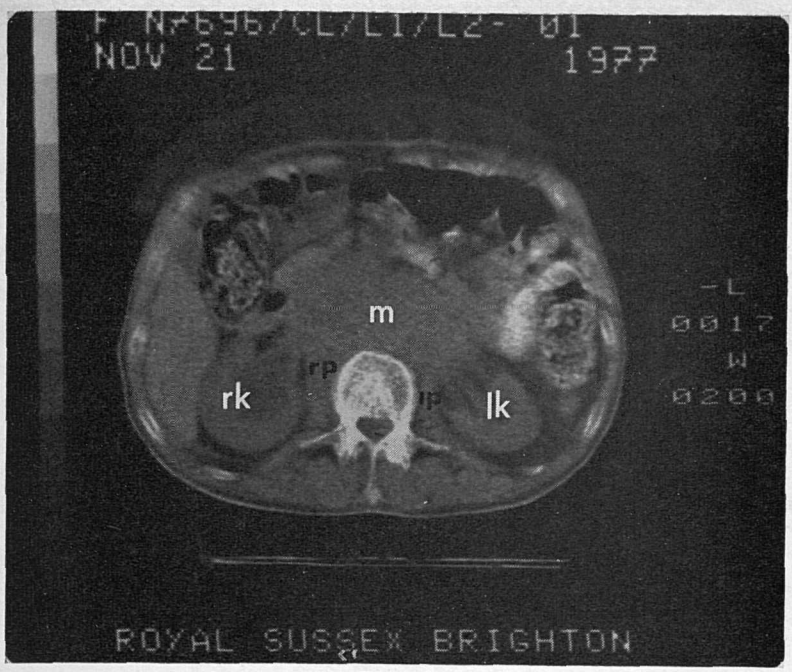


Fig. 14.

Male aged 36 with Hodgkin's disease. Confluent mass of para-aortic and mesenteric lymphnodes (m). Aorta and inferior vena cava obliterated by the advanced disease. Hydronephrosis of right kidney (rk) due to ureteric compression. Right psoas (rp) infiltrated by disease. Left psoas (lp) and left kidney (lk) are normal.

Pelvis (Fig. 15)

The position and extent of a bladder tumour can be shown with great clarity. The presence of extra-vesical spread can, as a rule, be demonstrated as well.

The size of a prostatic tumour, i.e. the whole prostate, is displayed on CT with great clarity in three dimensions. This is important for successful radiotherapy because a good treatment result is conditional on raising the whole target organ to a very high dose while sparing the adjacent rectal mucosa. The required high accuracy for pinpointing the prostate in this way can be achieved by CT to a hitherto unattainable degree of precision.

Malignant involvement of uterus, cervix and parametria can be demonstrated and, even more important, secondary spread to iliac lymph nodes can be ascertained by CT.

Fig. 15a. Patient aged 76 with prostatic carcinoma. Circle delineates target volume for calculation of optimal dose distribution on Rad 8 (computerised isodose calculator). Condition before radiotherapy. Base of bladder (b) containing Urografin and rectum (r) are also shown.

(For plate please turn over)

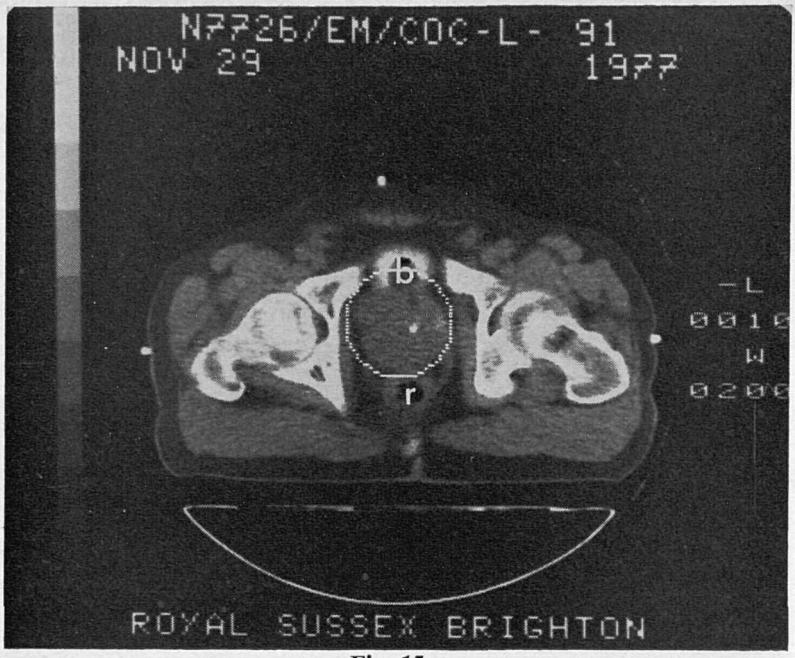


Fig. 15a.

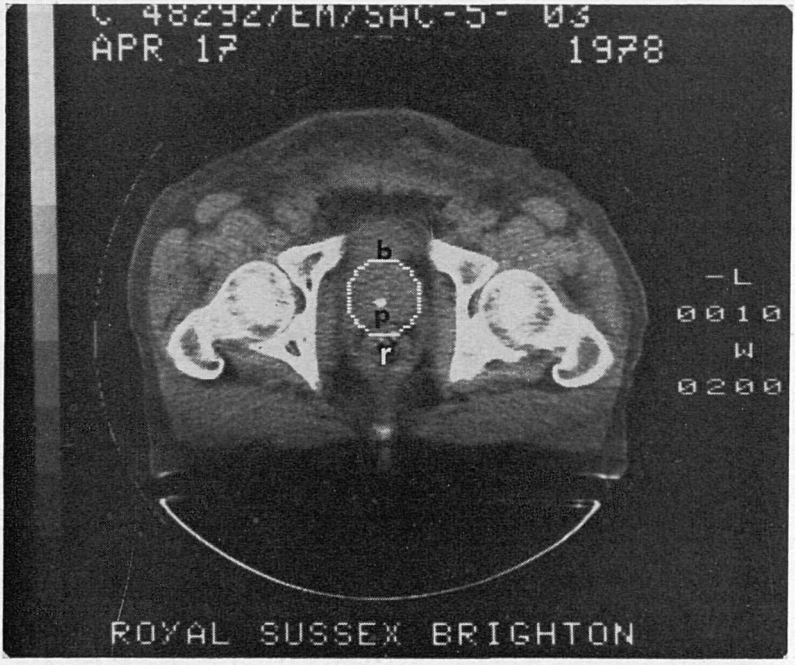


Fig. 15b.

Same patient as Fig. 15a. Condition seven months after radiotherapy, showing good regression. Prostate (p) outlined by electronic pencil. Base of bladder (b) situated anteriorly and rectum (r) can be seen posteriorly to it.

Summary

To conclude: On account of having substantially reduced the need for invasive diagnostic procedures, principally by virtue of its capability to detect a focal lesion, the whole-body scanner has significantly influenced medical thinking in its approach to clinical diagnosis and to surgical planning, particularly in oncology; furthermore, by substantially enhancing the accuracy of radiotherapy-technology and by making possible visual monitoring of tumour regression on treatment, the whole-body scanner has proved instrumental in significantly advancing the overall management of malignant disease.

General purpose (whole body) scanning and Guy's Hospital

Dr. A. J. S. Saunders

Department of Radiology

The multiplication of new techniques for organ imaging in the past decade has been remarkable. Ask a radiologist who retired in the 60's what he remembers as the most remarkable innovations, and he will probably mention the rotating anode and the image intensifier. A radiologist beginning his career in the 60's will already have seen the introduction of isotope imaging techniques, ultrasound, and now CT scanning. Each new method has made inroads into the domain of conventional radiology, whilst the latter continues to be developed and refined.

Conventional radiology continues to be the most used of the techniques of organ imaging. Nuclear medicine has introduced a physiological dimension. Ultrasound, due to its non-invasive character and absence of ionising effect, has established a place in cardiac investigation and obstetrics respectively.

The introduction of CT scanning for investigation of the brain has been of great benefit, obviating the need for painful and dangerous investigation requiring hospitalisation. As head scanning became accepted as a reliable technique, the capability was extended to other structures, particularly the abdomen and thorax. CT, however, has had to compete with other non-invasive and cheaper techniques. For example, the kidney can be beautifully demonstrated by means of CT. However, the introduction of safer contrast media, combined with conventional tomography, has led to consistently clear demonstration of renal anatomy. A three-dimensional picture can be built up by means of ultrasound scanning due to flexibility of the probe, allowing scanning to take place in planes other than axial.

A D.M.S.A. scan can demonstrate functioning renal tissue, and the radiation emitted can be quantified by means of a computer. Glomerular filtration can also be assessed by means of appropriate isotopes.

Accounts of the capabilities of the CT scanner with reference to specific organs are made elsewhere in this review, but its diagnostic contribution must be considered in the context of other presently available techniques.

Do we really need one at Guy's?

Whilst we have departments of Neurology and Radiotherapy at Guy's Hospital, there is no doubt that the answer is yes. Although facilities for head scanning are available at the Maudsley Hospital there will always be patients who are unfit to travel. Although the Nuclear Medicine department

can be of some assistance, the present situation is basically unsatisfactory. A general purpose scanner can of course produce acceptable head scans.

Even without the sophisticated computerised mapping devices such as the Rad-8, the ability to demonstrate tumour margins by means of CT would be an immense improvement on the present crude techniques. Staging of tumours could be made much more accurately, particularly in the exclusion of pulmonary metastases.

Where should it be sited?

Unfortunately, as in many teaching hospitals, our two major imaging departments, Diagnostic Radiology and Nuclear Medicine, are separate, both in organisation and in location. It is therefore less easy to avoid duplication of investigations than if there were a combined administration for processing referrals. It is also less easy to enable patients to complete as many investigations as possible during any one visit. Although there is a great deal of co-operation between the two departments, joint meetings and exchange of ideas are made more difficult. Ideally, therefore, a CT scanner should be sited in a department of diagnostic imaging and not in the department of Radiotherapy or in the medical school as has occurred in other hospitals.

A suitable room is available on floor three of the Tower; the floor that houses the B mode ultrasound machines and the angiography suites. The room at present contains a device for performing air encephalography, a technique made almost redundant by the advent of the head scanner.

How many examinations can be performed?

Various figures are quoted for the number of examinations possible, excluding head scanning, per day. The figures quoted by radiotherapy departments are usually based on patients being staged for extent of tumour spread. Enough cuts necessary to show the lungs and retroperitoneal tissues in Hodgkin's Disease can take one and a half hours. In this case it would be difficult to scan more than five patients in a day. However it would not take so long to answer a simple question: for example, is there a thymic tumour in a patient with myasthenia gravis; or, is the area of diminished uptake on a sulphur colloid liver scan due to a cystic or solid mass.

The scanner at the B.U.P.A. Medical Centre in Pentonville Road scans about eight to ten assorted chests and abdomens per day, and up to sixteen brains when using the machine from nine o'clock 'till six.

Clearly, if demand should exceed time available, some control of access would be required, and this would be best performed by radiologists who could not be accused of partiality to their own patients, and who also have experience in other investigative techniques.

Should we buy yet?

The attitude of E.M.I., who have been accused of slipping in the face of fierce competition, is that picture quality is not likely to improve greatly. Machines produced by other manufacturers with scan times faster than the 20 seconds available on the E.M.I. 5005 have in some cases led to poor picture quality. However, this is not true of the machine produced by Elscint which has a body section scan time of 10 seconds with excellent quality images. Innovations are more likely to occur in the computer facility. In particular reconstruction of images in different planes will overcome the present limitation to transverse axial cuts.

Godfrey N. Hounsfield
Inventor of the CT scanner
(Central Research Laboratories
of EMI Limited)

Invest in EMI's decade of CT experience

The EMI-Scanner CT system of today incorporates the benefits gained from more than 10 years experience in computed tomography, not only in technological terms but, more importantly, in the proven clinical performance of well over 700 scanners operating in 35 countries. Clinical scans of at least 4 million patients have proved beyond doubt that the EMI-Scanner's picture quality is the finest available, obtained with the lowest radiation dosage to patients.

To support our systems day and night, we have the largest dedicated CT servicing network in the world.

For the future, EMI Medical is committed to the continuing development of CT scanning systems to provide meaningful advances in diagnostic value, patient throughput and cost-effectiveness.

If you are considering adding CT to your radiological capability, protect your investment with an EMI-Scanner system and the CT experience for which it stands.

EMI Medical

A member of the EMI group
International leaders in
music, electronics and
leisure.

EMI Medical Limited
Windsor House,
3-7 Albert Street,
Slough, Berkshire, England.
Telephone: Slough 23855
Telex 849115

A centre in California is at present reconstructing images of the lumber spine sufficiently well to obviate the need for contrast studies in the investigation of back pain. Multiple closely approximated sections are required, though with an inevitable increase in radiation dose, in some cases up to 15R.

How much would it cost?

The present generation of basic E.M.I. general purpose scanners (CT 5005), cost £270,000 each as opposed to £220,000 for the CT 1010 head scanner, and £26,500 for a grey scale Diasonograph ultrasound machine. E.M.I. is to produce a new scanner, probably by early 1979, which will have a faster scan time than the present model, but will cost in the region of £380,000 to £450,000. In addition to capital expenditure the servicing contract costs £22,000 per year, and there will also be salaries required for two radiographers and a consultant radiologist or senior lecturer. There would also be some need for increase in secretarial staffing and portering. At present Guy's sends some patients to the B.U.P.A. centre at the cost of £120 per examination.

Perhaps these sums of money can be put in perspective by considering the budget for replacement of ageing X-ray equipment for the whole of the South-east region, which includes all N.H.S. hospitals in Kent and east Sussex, plus three London teaching hospitals. The budget for the coming year is in the region of £800,000. Not much change after buying only two scanners.

Who will pay for it?

The official line from the Department of Health has been that it is waiting for the results of evaluation of the machine at Northwick Park before committing itself to the purchase of further general purpose scanners. In the present economic climate, and especially following the recommendations of the re-allocation of resources working party (R.A.W.P.), it is clearly going to be very difficult to persuade the region to provide finance. Indeed we are still finding it impossible to increase the number of consultant radiological sessions for New Cross Hospital from the ludicrously inadequate three sessions at present provided.

Most teaching hospitals that have acquired a general purpose scanner have had to find the money from their endowment fund. Financing salaries for staff may in some cases have been provided by private institutions, businesses, etc., with rights of access for their staff, and having their name associated with such a project. A working party has been set up at Guy's to explore various ways of acquiring the necessary finance.

Conclusion

Following the undeniable benefits of the head scanner, there has been a tremendous scramble, particularly in the U.S.A., to buy general purpose scanners, regardless of cost, a sort of CAT fever, which has led to criticism from those who feel that there are more deserving causes. Some have come to regret their haste. A private hospital in Perth, Australia, has recently been obliged to sell its machine, there not being enough patients in whom the investigation could be justified, and still make a profit. It is most unlikely that a machine at Guy's would be underused especially with the benefit of avoiding multiple investigations, including laparatomy. It

would also lead to more accurate diagnosis, particularly in neoplastic diseases. It is, however, vital that both clinicians and those concerned in running investigative departments endeavour to use the facilities available as efficiently as possible, and thereby help to justify the introduction of new technology. There is no doubt that if Guy's Hospital is to remain a referral centre of international repute it must have the best investigative facilities available, and in my opinion this includes general purpose CT scanning.

THEATRE

The two plays reviewed in this issue have only one thing in common. They are both comedies about very serious issues. The first is a "must" for anyone who likes good theatre, while the second should be avoided by anyone with the remotest trace of sensitivity.

"Every Good Boy deserves a favour" (Mermaid Theatre and very close to Guy's) is another in the increasingly long line of Tom Stoppard's successes. It concerns a dissenter incarcerated in a Russian Mental Hospital, who has to decide whether to follow his own political conscience, or to concede to the authorities in the interests of his vulnerable young son. But even if you have never heard of, or sympathised with the "dissenters", you should find it enjoyable.

The scene is set in a two man cell, that is to say ward, of a Russian Mental Hospital. One of the inmates, called Ivanov, is under the delusion that there is an orchestra "chasing" him, and his life is being continually interrupted by having to conduct it (which is where André Previn and the on-stage orchestra come in). The other inmate, also called Ivanov, is a dissenter. Or more accurately he objected to a friend of his, who had been put in a mental hospital, who had objected to a friend of his . . . criticising the Russian authorities. Why both characters are called Ivanov, I shall not tell you.

They are both in the wonderfully incapable hands of the doctor (Frank Windsor). Doctor? you say, well in his own words, "I am happy to serve the state in any way that I can". He is himself a little obsessed with music (thus giving a further outlet for André Previn's qualities) and therefore needs to emphasise his own sanity. "I am a doctor, you are a patient, that is a distinction that we like to keep around here." The Laingian theme, however, is not overdone. Besides his eccentric prescriptions such as laxatives for schizophrenia, which are at least harmless, the doctor has been given some of the best lines in the play. When Ivanov, the dissenter, won't toe the party line, the medical man's patience is lost—"You know Ivanov, you're off your head besides being a paranoid schizophrenic." He also tells a story about a patient of his with an identity problem, but of course, he is unable to remember his name.

The fourth character is the terrifying colonel, who is in charge of the whole hospital. He makes a powerful entrance through the audience, making most of them cringe in their seats, and exits in the same way, but has lost his tenor by them.

The serious side of the play should be quite familiar to many people at Guy's since Marina Voikhanskya, who was herself a psychiatrist in the

Leningrad Mental Hospital, spoke to Quodlibet last year. Some of the text such as the doctor saying "your disease is dissent", comes direct from trials, or Government sources. The little boy, who calls for his father to come home is reminiscent of Marina Voikhanskya's 11 year old son Misha, whom the Soviet authorities are refusing to allow to come to this country. It is sad that the serious work done by Stoppard, and some of the others in the Campaign Against Psychiatric Abuse is now being undone by the rather ham-fisted, and certainly less effective approaches made on the World's Stage by men such as Mr. Carter.

I am quite unqualified to consider André Previn's rather special musical contribution to the play, except to say that it does add a great deal to what is said.

"Once a Catholic" by Mary O'Malley (Wyndham's) follows the progress of a class of girls doing their "O" level year in a North London convent. It studies the Catholic "indoctrination" that the girls are exposed to, and their reactions to this indoctrination, especially as far as sex is concerned. This would seem to provide a rather original setting for a new look at all those hackneyed issues such as abortion and the pill. What actually comes out of it, however, is a mean and unpleasant play. In fact it is more of a farce than a play, whose wit and profundity never exceeds that of an "O" level schoolgirl, and frequently goes far beneath it. "By the time the play is finished," Mary O'Malley says in the programme, "I had written Roman Catholicism right out of my system." The remark is not surprising in view of the play's gross-over-simplification of the intricacies of the Catholic process.

Such comments, you might say, must come from either a prude or a Roman Catholic. (A letter to *The Times*, recently, pointed out that most of us are catholics, only a few of us are *Roman* Catholics.) I am, however, neither. Indeed, like most protestants, I am very annoyed by those silly pronouncements by the Vatican on sexual conduct, especially contraception, and have little doubt that they cause far more unhappiness than Mary Whitehouse and Linda Lovelace put together (which I am sure that God will forbid that they ever should be). Nevertheless, I do draw the line at what were apparently the funniest parts of the play, when one schoolgirl puts a penis on the crucifix and when another called the Mother Superior a f—— old c——. Such gimmicks are not shocking or disgusting these days, but they are tasteless and boring. Most of the play, I should add, is about the girls saying naughty things to each other, to the nuns, or vice versa. The farce does go even lower though, with the usual ribald jokes about Hendon and Willesdon, some kitchen sink innuendo on the subject of "dry cleaning" souls, and even a few very old chestnuts such as the priest having the inevitable back trouble.

On the good side there is little to say. I like the description of the Catholics as people, who "drink too much and fight among themselves", but it is a romanticisation to say "the protestants don't have sins the lucky s——". Some of the vocabulary is apt too, with the idea, for instance, that if the girls have sex with boys, the boys will hold them "in contempt".

At the end of it all, nevertheless, we are left not with a play so much as a two and a half hour schoolgirl's prank. I was going to start by saying that the performance was "Christ crucified in the West End". But now I've finished with it.

Michael Dixon.

RAY & GILL WARREN

welcome you
at the

WHITESMITHS' ARMS

01-407 0510

Music Every Lunchtime

37 CROSBY ROW
SOUTHWARK
S.E.1

D. J. Thurs. - Fri. Sat. - Sun. Evening

BEST BITTER

DIRECTORS' BITTER

TAVERN

JOHN COURAGE

GUINNESS

LAGER

HOT and COLD
SNACKS
12 p.m. to 2.30 p.m.

NURSING

Nurses and Administrators

During recent years there has been, much to the chagrin of the medical and nursing professions, a mushrooming in the population of hospital administrators. This has been particularly noticeable during the four years since the Health Service was reorganised.

It is of course true that such individuals have always existed in the form of hospital secretaries, treasurers and a variety of other capacities, but they usually managed to work in harmony with colleagues and their presence was no more apparent than that of other disciplines.

Nowadays however, the situation is somewhat different. There are unit administrators, Sector administrators and a multiplicity of other varieties, all of which appear to have the same responsibilities as were allotted to one person formerly.

The increase in the numbers of these people has caused considerable misgivings on the part of Doctors and Nurses, and whereas it can be argued that both groups are very prejudiced and resistant to change, the fact that such strong feelings exist cannot surely be overlooked. It may then be worth considering some of the reasons for the antipathy.

It is of course true to say that Doctors and Nurses do not on the whole, make good administrators themselves. The doctors because they are too egotistical and the nurses because they have not the ability. This fact is therefore likely to cause frustration to the young and possibly competent administrator who has come straight from training and is anxious to prove his ability. Therein though, lies the rub. These people have little if any hospital experience and have, in all probability never seen a patient alive and certainly not one who is dead. Their aggressiveness and failure to communicate with colleagues who could give advice, has created for them a very poor reputation, so that now, even those who do manage to establish good working relationships have to bear the stigma.

Another source of grievance has been the fact that whereas doctors and nurses have to provide a full twenty-four hour service the administrators do not. They do however wish to assume complete power during the day, whilst making responsibility at night and at weekends the vicarious duty of others. Since this constitutes something like sixty per cent of the time one may well ask why they are necessary for the other forty per cent.

In some areas, the antagonism has lessened a little but there is still a feeling that administrators are oblivious to the needs of the patients and concerned only with empire building. Until the medical and nursing staffs adopt a more flexible attitude and the administrators recognise the fact that patients are the reason for their existence there will be no amelioration of this.

Pam Jeffries.

PHYSIOTHERAPY

Physiotherapy in the Community

This is the title of a "descriptive study of fourteen schemes" which in one form or another have taken treatment to the public rather than vice versa, and which has been prepared by the Health Services Research Unit of the University of Kent. We have been interested in this kind of involvement for some years, but really have only positively acted since we decided to "open" the physiotherapy department to direct G.P. referral, so reducing the interval between the making of a diagnosis and the institution of appropriate treatment, and, at the same time, decongesting the waiting-lists for consultant appointments. Subsequently, arising from discussion of the Priorities for Health and Personal Social Services consultative document, we advertised for and appointed an experienced physiotherapist to range over the District, and attempt to evaluate the need for treatment to be given in places other than hospital departments.

Unfortunately, the scheme came to a stand-still after a promising beginning, as the physiotherapist was unable to continue, and we could not easily find a replacement. Partly, this was because suitable people are not in plentiful supply, but it was also because we had had to remove a senior from another sphere of hospital employment in order to create the post, and we could hardly afford to repeat that procedure. However, a re-arrangement has now been made which has released one of the departmental seniors, and since the middle of July she has been able to step into the community role and start picking up the threads once more.

It should be reiterated that, in the first instance, she is there to investigate the demand and the need. To quote the study referred to above, "it is necessary to know how many people in the community have (relevant) conditions, how many need physiotherapy, what physiotherapy is needed and the consequential requirements for staff and facilities". In a District like ours, fairly densely-populated and with a public transport system terminating on our doorstep, it may turn out that there is no economic justification for sending therapists out rather than calling patients in. Perhaps, again, a part-timer working for a few hours a week would suffice. At any rate, it seems unlikely that most of us would take to the Health Centres and the group practices and leave just a handful in the hospitals to treat the in-patients, but we really ought to know rather than just speculate. We thought a year would be a reasonable period for this initial study, but of course, the lengthy hiatus in the middle will mean that the actual interval between starting and concluding will have been much longer.

Eventually, we may add a junior member of staff on one of her "rotations", and, if all goes well, attach one or more third-year students so that they gain some experience of this type of work and have the opportunity to appreciate the differences between it and that met in hospital practice. This would accord with the recommendations of Partridge and Warren and would seem a sensible placement.

Ronald Cooper.

CORRESPONDENCE

From the Action Committee E.G.A.

Sir,

I was sorry to see you describe the many well-informed and objective debates which have taken place in the House of Lords and the House of Commons about the Elizabeth Garrett Anderson Hospital as shrill cries. I am assuming you have not based your opinion on reports in the daily Press, but taken them with a pinch of salt.

However, I want to reassure you about the "customers". They have, indeed, been consulted about the Hospital's future. Over 25,000 signed a petition presented to the Prime Minister. Their voice, too, has been raised in emphatic support through the important women's organisations. Local women, many of whom you might describe as "women's lib" are very vocal in support of the Hospital. Thousands, if not millions of women have made it clear where their wishes lie.

The E.G.A. Hospital supporters do not claim that all women want to consult women and be cared for by women, but they know that sometimes women prefer to see women, just as men may prefer, on occasion, to consult men, and they believe the choice should be available in their National Health Service. The E.G.A. "customers" have, in fact, increased in the past years, in spite of the Hospital's crippled state.

The problems which bring them to the E.G.A. are by no means always gynaecological. General Surgery, Medicine, Dermatology, Psychiatry and Rheumatology all attract customers.

Your interesting suggestion that the medical care of women needs a fresh approach chimes with the views of many groups of "lay" women who are urging that the E.G.A. be enabled not only to survive, but to take a more active part in activities and research designed to prevent ill-health and to promote well-being among women.

It would be very encouraging if your editorial stimulated Guy's doctors to appraise their practice afresh so that patients might enjoy the care which I, as a woman patient, have received from so many of the Guy's consultants.

Yours faithfully,

JEAN LAWRIE.

Elizabeth Garrett Anderson Hospital,
London, NW1 1YA.

Occupational Medicine

Sir,

As a follow-up to the excellent *hors d'œuvre* on this subject by Dr. Suzette Gauvain and your interviewer Philip Razzell, may I, as a recently "converted" Guy's G.P. offer a "fish course", hoping that someone more experienced may provide the "meat" to follow?

As mentioned on page 193 of the May *Gazette* the four nationalised concerns quoted, inevitably omitted others, e.g. British Gas, Post Office and British Rail. Several other companies, e.g. Walls, Cadburys, Whitbreads, have substantial Occupational Health Services with full-time Doctors and Nurses.

I left General Practice after 14 years and have been with the British Rail Board Medical Department for five years. The Board has 25 full-time Medical Officers throughout the United Kingdom, and I am fortunate to have Wessex, the Isle of Wight and Channel Islands in my Area; looking after Railwaymen, Workshop Employees, Ships' crews, Dock Workers, Road Transport, Catering and Transport Police staff.

As Sir Hedley Atkins offered visits in his article on Down House in the same *Gazette*, if any of you have leanings towards Occupational Medicine, I shall be pleased to tell you of my experiences so far if you care to contact me at the British Rail Medical Department, Southampton Station.

I can only endorse each and every answer Dr. Gauvain gave in her interview as being both accurate and bang "up-to-date"! In fact the situation in Occupational Medicine at this time is very similar to that of General Practice, when the College of General Practitioners was being inaugurated in 1952!

Yours faithfully,

DAVID TUDDENHAM.

Divisional Medical Officer, British Rail,
Overline House,
Southampton Station, SO9 3BA.
Tel. Southampton 22492

Where Lies the Blame

Sir,

Hospital patients and taxpayers in Britain today are asking why hospitals are in such a perilous position due to the shortage of nursing staff. It can be no consolation to those nurses in control of nurse administration to read that the number of nursing staff in hospitals

in the employ of the Health Service would be adequate if they were economically deployed.

No informed person can today be in any doubt that the most urgent problem to solve is that of the continued costly ruinous wastage of student nurses. WHY do these hand-picked young women who have chosen to accept the challenge which nursing training will always be, decide to opt out during their first few months on the wards? *I do not believe* the tales of dragons of ward sisters being the cause.

Why is it getting harder and harder to attract and keep full-time trained staff on the wards?

Why was three million pounds of taxpayers' money recently spent on nurse recruitment? Pay has little to do with nurse recruitment of trainees today when eager employers in offices and in industry are offering far greater money rewards that nurses will always have to be content to receive. Employment of part-time and agency nurses will always be fraught with complications and added expense and cannot at best be little more than a stopgap.

The overall situation today is such that the view of Professor Crossley, economist, who sat on the Briggs Committee should be widely known. His views are that owing to the failure of nursing administrators to solve the problem of staff shortages those nurses at unit level, i.e. in the wards, should now be brought into the picture. These ward sisters and staff are vitally interested in the deployment of nurse labour. Ward Sister, Miss Veal and her colleagues bravely raised their voices regarding conditions of work in women's wards—*their voices were silenced.*

Today there is an urgent need to introduce change into the traditional time wasting repetitive nursing jobs in the wards. Modern tools can help but the overall need is to revolutionise PROCEDURES and until this is done there can be little or no progress in staffing Britain's nationalised hospitals with contented nurses in quality and quantity.

In fairness to politicians—should they take the blame? They have looked to nurses and given them power and opportunities to place nursing onto a modern footing. That nurse planners in the corridors of power at the Ministry and on the Regional Hospital Boards have fallen short of what was expected of them is not the fault of the government.

Yours faithfully,

MARY GRANT.

Albury, Guildford, Surrey.

What is wrong with the N.H.S.?

Sir,

Dr. Smith in responding to my article "What is wrong with the N.H.S.?" provides the usual catalogue of faults which seems to owe more to the love of the media for newsworthy stories than to serious analysis. In particular his observation that the N.H.S. is now "a collapsing, third-rate, impersonal and financially-hamstrung apology for a health care delivery plan" seems a bizarre assessment given the overwhelming public satisfaction with the service (I suppose that is the trouble with the great British public—they never know when they should be miserable).

I was further confused by Dr. Smith's suggested solution to our problems: "a return to a less restrictive form of practice." I cannot be sure which particular epoch he had in mind. Was it the era of the Poor Law and of G.P.s dominated by the "Club" system? Or was it the inter-war "panel" system of workhouse hospitals and a financially imperilled voluntary hospital system? Or perhaps the early N.H.S. with its disillusioned GPs, its outdated facilities and regional inequalities, its hospital scandals like Ely and Farleigh? No, I am afraid that the illusory achievements of a Golden Age offer a feeble standard by which to understand our current problems.

Yours faithfully,

DAVID ARMSTRONG.

Unit of Sociology as Applied to Medicine,

Guy's Hospital Medical School,
London, SE1 9RT.

From Lane to the Milk Churn

Sir,

On a recent ward round I was introduced to Mr. Lionel Scott Langley who had been admitted with a minor emergency. Although described as a retired naval officer I noticed he was wearing a Guy's tie and aware that these can be purchased at Woolworths and other stores it was jokingly that I asked him when he was at Guy's. To my surprise he replied by saying that he was there from 1910–1914 having been invalided from

Mr. Lionel Scott Langley is situated just beneath the flag, with a piece of squared card on his top hat.

The Milk Churn.

Action at a Hospitals' Cup game of 1910.

the Navy in 1910 and taken up medicine. However, at the onset of World War I his injury was not considered serious enough to exclude him from returning to the Royal Navy and his medical career ended.

My ward round was greatly extended by allowing him the opportunity to reminisce of those times long ago and I was treated to a first hand account of historical events. He recalled many legendary names that are so familiar but in particular fascinated me by describing various surgical techniques that were practiced by Sir Arbuthnot Lane while he was assisting him. With remarkable detail for someone out of the medical field for so long he was able to describe Lane's steps in the operation of total colectomy, a procedure which latterly earned a fair degree of notoriety. He was further able to talk of the man and his prejudices. One such prejudice was towards anatomists. He asked of Scott Langley one ward round of his definition of the human skeleton. His anatomist's definition was rebuked and Sir Arbuthnot in almost poetic terms, alas so rare these days, succinctly described the skeleton as the "crystalisation of forces within the human frame".

Even more fascinating, however, was that he claimed to have been one of the three chaps who originally purloined the Guy's milk churn from a railway station and he has furnished me with pictures of a hospital cup game of 1910 which I enclose. Apart from the clothes the scenes are not a lot different from what we have come to expect now, though I notice that on this occasion there seems to have been no necessity to handcuff the churn to its custodians. Mr. Scott Langley is the gentleman situated in the centre of the photograph of the students on the Guy's front hall steps with the piece of squared card on his top hat. He is now at the ripe age of 94.

Any students of Guy's history might like to take the opportunity of meeting Mr. Scott Langley. He is very fit and active and at all times has been only too pleased to reminisce about his happy days nearly seventy years ago. He presently resides at a nursing home at Budleigh Salterton and I would be only too pleased to forward his address to anyone who is interested.

Yours faithfully,

K. M. PAGLIERO.

Royal Devon and Exeter
Hospital (Wonford),
Barrack Road,
Exeter, EX2 5DW.

From SLICKER

It was 2.30 a.m. in the morning, two nurses were crawling on all fours trying to get back into the nurses' home without being seen . . . "Isn't this fun, Pauline?" said one. "Yes," said Carol, "I feel like a commando."

" Don't be daft Carol," said the first. "Where are we going to find one at this time of night?"

This is just one of the finer examples of Quoteable quotes heard in and around Guy's this month, and Slicker Publications Gossip Columnist, Miss Anna Rexia-Nervosa, was there to record them for posteriority.

"It's the Schizophrenics Conference in Brighton this week, I've half a mind to go."

"If it wasn't for all these bloody Doctors we'd be able to park in this Hospital."

"If a doctor takes himself a wife, he should make love to her Daily, and if the daily objects he should try the Au Pair."

"Circumcision . . . the unkindest National Health cut of them all."

"I'm sorry Sir, there's only two diseases I can recognise, one is Tonsilitis, and the other isn't."

"You know Sir . . . there's only one way to get rid of that ugly 200lbs. of excess fat." "Oh yes Doc, what's that?" "Get a Divorce."

"The Clubs' Union Council is a gathering of important people who singly can do nothing, but together can decide that nothing can be done."

"Excuse me mate, can you tell me the way to Guy's?" "Man, you just got to be born unlucky."

"You know Father, there are two things I can't stand in life, Religious Intolerance, and those darn Methodists."

"This year's Schizophrenics conference will be held on July 30th at 2.00 p.m. in Brighton and Manchester.

SLICKER Publications.

From the P.F.L.A.

Sir,

We were horrified to hear of the death of the graffiti in traps 1 - 5, Floor 24. Guy's has an ancient and honourable tradition, which arises from generations of students who have lived, worked, eaten and slept in Guy's Hospital. This latest outrage against mass civil rights represents an intolerable attempt to erase such character by the Platternalistic administrators of the hospital.

The Tower, for various reasons, has little of the character and aesthetic qualities evident in other parts of the hospital, and this latest affrontery demonstrates a real attempt to exterminate any effort to develop morale amongst those who work within the building.

It is true to say that some of the prose which is no longer with us is better forgotten, but to erase all record of present day wit and character is an intolerable price to pay.

If, as is alleged, the cleaners were so offended that they could not carry out their duties in the toilets, we recommend the employment of the cleaners who work in the residents bar (Boland House) to carry out these duties.

We are confident that this attack on morale will not be taken sitting down, and the "real Guy's" will be back (soon). Like all reasonable people, we abhor this action, and we will not rest until this Vale of secrecy of administrative methods is exposed.

For the People,

I. BLONDSTEIN.
FRANK WEBB.

p.p. Popular Front for the Liberation of Aaardvark.

BOOK REVIEWS

"The Healer's Art. A new approach to the Doctor Patient Relationship," by Eric J. Cassell. Pp. 208. Price £1.10. Published by Penguin.

This small book argues for a "whole-person" approach in medicine, towards healing the person rather than curing the disease. The argument is presented through case histories which in themselves are supposed to confirm the correctness of this approach (perhaps inductive reasoning is the only way of encapsulating humanism in medicine).

The sub-title of the book, "A new approach to the doctor-patient relationship", makes an unwarranted claim but it does provide a useful corrective to that form of medicine which emphasises the abstracted pathology of the exclusion of the sick-man.

DAVID ARMSTRONG.

"Histology", 2nd edition, by Peter S. Amenta. Pp. 242. Price £7.50. Published by Henry Kimpton, London, 1978.

This book provides a concise, accurate review of histology suitable for B.M.S. and 2nd B.D.S. students. Based on the lecture course of its author, a professor and chairman of anatomy at the Hahnemann Medical College and Hospital of Philadelphia, it concentrates on the salient and clinically relevant aspects of histology and does not attempt an exhaustive treatment of the subject.

The contents of the book are clearly organised. After a brief consideration of histological techniques, the structure and function of cells and the histology of the various tissues, organs and systems are described. The material covered is arranged systematically in note-form in a readable and memorable fashion. Wherever possible the Nomina Histologica, recommended by the 9th International Congress of Anatomy, is used. Important terms are capitalised and lucidly defined. Wherever appropriate, features of clinical significance are emphasised.

Unfortunately, this book contains very few diagrams and photomicrographs, an omission acknowledged by its author, who recommends that, in place of these, slides and electron micrographs should be examined directly, using the text as a guide to their interpretation. The danger here is that of misinterpretation, and I recommend that if this book is acquired instead of a standard histology textbook, it should be used in conjunction with an atlas of histology.

MARY DYSON.

"Manual of Basic Neuropathology", by Raymond Escourolle & Jacques Poirier translated by L. J. Rubenstein. Pp. 242 + XIII. Price £8.50. Published by Saunders.

This second edition of the English translation of Escourolle & Poirier's Manual of Basic Neuropathology is an excellent book. Nowhere else is it possible to obtain such good coverage with instructive illustrations in such short space. This book is invaluable for advanced undergraduate students, for postgraduate students and for pathologists in general: it can be strongly recommended with confidence. The English translation by Lucien Rubinstein reads so clearly that the book might well have been originally written in this language.

C. W. M. ADAMS.

"Precision Attachments" by G. E. Ray. (Dental Practitioner Handbook No. 7 2nd Edition) pp. 157. Price £5.25. Published by John Wright.

The author states in the preface he has produced a mini text on Prosthetics with special reference to attachments, based on 30 years of clinical experience. Regrettably it has proved impossible to condense this mass of information into such a small volume.

The illustrations are dark and do nothing to improve clarity though the numerous line drawings provide a welcome distraction from the text. The nomenclature is in some place confusing and in others ridiculous e.g. semi-removable bridge! The term "connector" in relation to a particular type of attachment may cause some confusion with other partial denture components. Many of the ideas stated are the personal opinion of the author. For instance, it is suggested that a "comfort free-way" should be provided where a distal extension saddle is present. This is achieved by allowing resorption to reduce the occlusal load on the saddle and not relining it. This may result in over-eruption of the teeth in the opposing arch. Also in this section the theories regarding mucostatic and mucofunctional impression techniques are poorly explained.

The book contains a considerable amount of occlusal physiology which is out of place in such a text—a reference to a standard work in the subject would be of more value. The use of study models has only a few lines whereas a page is devoted to Auscultation of the TMJ- Periodontal evaluation of the abutment teeth and the use of guide planes receives very little attention.

This book will prove of little value to practitioners or students with an interest in attachments. The first edition of the book included tables of the more common attachments with their sizes and applications which may occasionally provide quick reference for particular attachment requirements, and thus had a useful place on the bookshelf. These have been omitted from the second edition which has little to commend it. There are far more authoritative texts at around the same price.

W. A. V. BEARE.

SPORT

Russell Brock v. Starling

The generally quiet village cricket ground of Plaxtol was the site of yet another battle between the surgical team of Russel Brock and the medical team from Starling.

A general concensus resulted in the decision that:—

(a) Each team should have one ninety minute innings or two overs per team member.

and

(b) There was to be no kissing or hugging when runs were scored . . . this was serious business.

The surgical team had first innings, their first batsman was soon stumped out by the wicket-keeper for Starling—David Raper—who was no doubt hoping he would not get a cricket ball in his eye—"a close encounter of the second kind".

Next into bat was Krisna Nair—a keen man—having travelled all the way from Hull for this grande criquet tour.

Russell Brock's second batsman was caught out by Starling's Alan Edwards who was fielding in true Aussie style but looking as if he had gone astray from the cath. lab. (Wrong sort of Whites Alan!)

Fourth into bat was Mr. Yates who approached the wicket wearing a "box" over his vital organ! (Heart). He was all prepared to demonstrate how cricket should be played only to be bowled out by Dr. Humphries.

However Mr. Yates did score three runs without even moving, as Dr. Humphries was bowling rather wide. (They obviously don't play cricket at the Johns Hopkins?)

The female members of the Surgical team followed in quick succession. The late arrival of John Pepper caused a few sighs of relief as he went into bat to bring the score for the Surgical team to 108 for 8 wickets when they declared after 90 minutes.

The Medical team began their innings intending to repeat last year's victory . . . The team consisted of rather a lot of "Hey-Ho" female cricket players including the first two batspersons Rhoda "Hey-Ho" Walton and Jill "Hey-Ho" Nuttal.

Next in AND out was Tom Humphries —maybe these Baltimore people should stick to baseball!

In came yet another "Hey-Ho", this time of the Hellen Newton variety—again a short innings.

Starling played their "A.C.E." next and in doing so improved their score considerably. When Alan Edwards was out he was replaced by Peter James who put on a pretty good show along with his co-star Teresa Comba.

An exhausted "Hey-Ho" Comba was caught out after a very good innings—and somewhat relieved she staggered to the sidelines. Victory was sighted as John Karani topped a score of 109 before being stumped.

Refusing to declare, Starling fought to the end with John Rees having a very short innings—but this was followed by the grand finale of David Roper who hit a six and was then caught out! This brought the final score to:

Russell Brock	108 for 8
Starling	117 for 6

HOSPITAL'S CUP SEMI-FINAL
Guy's v. Westminster

The state of Guy's cricket being what it is at the moment it was no shock to see Guy's struggling to get a team out on the 8th of July. However, what was amazing was that this was for the semi-final of the Hospital's Cup.

In the end "The Magnificent Nine" trooped out at Cobham—minus people who, had broken toes the day before, had relatives with backache, who had cars to repair and who didn't have the courtesy to reply to notes.

A relatively normal start was made with Jacks and Sheridan making two runs between them. However the innings was propped up by Glover (60), Rees (62) and Shepherd (45) and closed by the enthusiastic substitute's (Simon Moore) forehand volley first ball at 189.

Guy's were in with a chance when Westminster were 115 for 5 thanks to the bowling of Shepherd (3 for 55) and Jacks (2 for 64) but the opposition came through to win by 4 wickets.

The Junior officials would like to wish all members and their families a speedy recovery from illness.

"DISGRUNTLED."

Magnus in the Mountains

The other week, an old friend of mine, Magnus Bone, met me in the Bar. I had already downed a few beers and was lamenting in an alcoholoquent manner, the dearth of any news from the climbing world in the latest *Gazette* sport report. Immediately realising the full potential of my state, he suggested that

I should put pen to paper and write an article for the next issue: The lure of yet another pint was too much—I succumbed.

The aforesaid incident was completely forgotten by the following morning amidst headache, aspirin and black coffee. However last Friday, Magnus approached me in the Colonnade. He enquired how my article was progressing, and informed me that as copy date was Monday, would I kindly leave my article in the pigeon hole in the East Wing by noon. A surge of panic came over me: especially when I realised that I was going away for the weekend drinking—combined with sailing this time, and not the relevant climbing. However, when needs must, time can be found, and it was: just!

Over the past few months, a few climbers have traversed out of "the Globe" on Friday lunchtime (a gregarious bunch when not on the rocks). With gear including nuts, slings, crabs and "bonedomes" they have piled into assorted "Welly waggons" and "Sin bins" and driven all over Great Britain to places like "Cobdens"; the Clay Haig (sp!)" and "The Hathersage Inn". The first attempted traverse of a moving 1969 Ford Zephyr, on one of these journeys, culminated with the "necky" climber spreadeagled on top of the roof. Any self respecting climber knows that it is always harder to reverse a move!

When not climbing rocks or the like (the only physical element of this sport), most of the time is spent recounting tales of great strength (the little finger pull-up?) and daring (—and there we were, etc.!) in the pub. A leading member of our union, who actually fell about 10ft., whilst climbing on Cwm Silyn, had almost fallen past Australia by the end of the evening's drinking and talking. But drinking can be medicinal too: Fowler's "Wee Heavie" is particularly recommended as an effective vasodilator for frostbite—physicians take note.

Enough rambling. Mountains combine to fascinate a few of us—keep your ears open, you may even hear talk of climbing in the Bar.

ROB DAVIS.

HOSPITAL INFORMATION

PAPERS BY GUY'S MEN

Bewick, M. *and* Ogg, C. S. . . . and when conservative measures are no longer enough. **Modern Medicine,** 1978, **23**(6), 28.

Bewick, M. *and* Ogg, C. S. Renal failure: managing the preterminal phase . . . **Modern Medicine,** 1978, **23**(6), 25.

Day, L. J. *and* Sowton. E. The treatment of angine pectoris. A trial of perhexiline maleate in patients with angiographically normal coronary arteries. **Practitioner,** 1978, **220,** 965.

Emslie, R. D. Some considerations on the role of cementum in periodontal disease. **Journal of Clinical Periodontology,** 1978, **5,** 1.

Garcia-Fuentes, M., Martin, C. I., Chantler, C. *and* Williams, D. G. Serum complement components in Henoch-Schönlein purpura. **Archives of Disease in Childhood,** 1978, **53,** 417.

Goudarzi, H. Painful young bellies. (Correspondence.) **British Medical Journal,** 1978, **1,** 1486.

Harrison, T. A. Portal phlebothrombosis: the role of thrombectomy. **Annals of the Royal College of Surgeons of England,** 1978, **60,** 320.

Iser, J. H., Maton, P. N., Murphy, G. M. *and* Dowling, R. H. Resistance to chenodeoxycholic acid (CDCA) treatment in obese patients with gall stones. **British Medical Journal,** 1978, **1,** 1509.

Jefferys, D. B. *and* Efthimiou, J. Carcinoma of the male breast and oestrogen metabolism. (Correspondence.) **British Medical Journal,** 1978, **1,** 1697.

Lehner, T. *and another.* Circulating soluble immune complexes in recurrent oral ulceration and Beçhet's syndrome. **Clinical and Experimental Immunology,** 1978, **32,** 193.

Lessof, M. Clinical immunology. **Update,** 1978, **16,** 1267.

Prieto, F., Cochrane, G. M., Clark, T. J. H. *and others.* Spirometry in healthy men: a correlation with smoking and with mild symptoms. **Thorax,** 1978, **33,** 322.

Simmonds, H. A., Sahota, A., Potter, C. F. *and* Cameron, J. S. Purine metabolism and immunodeficiency: urinary purine excretion as a diagnostic screening test in adenosine deaminase and purine nucleoside phosphorylase deficiency. **Clinical Science and Molecular Medicine,** 1978, **54,** 579.

Vale, J. A. *and* Jefferys, D. B. Peripheral gangrene complicating beta-blockade. (Correspondence.) **Lancet,** 1978, **1,** 1216.

Yates, A. Dopamine and dobutamine. (Correspondence.) **British Medical Journal,** 1978, **1,** 1622.

Alberman, E., Collingwood, J., Pharoah, P. O. D., Vaizey, J. *and* Oppe, T. E. (1977). Arrangements for special and intensive care of the newborn. **British Medical Journal, 2,** 6094, 1045–47.

Alberman, E. *and* Peckham, C. (1977). Long term effects following infections in pregnancy. In: Infections and Pregnancy. Coid, C. **Ed.** Pp. 489–514. London, New York, San Francisco.

Child, A. H. *and* Denins, N. R. (1977) The genetics of congenital heart disease. *In*: Birth Defects: Original Article Series. Vol. XIII, 3A.

Numerical taxonomy of birth defects and polygenic disorders. Bergsma, D. *and* Lowry, R. B. **Eds.** Pp. 85–91. New York: Nan R. Liss Inc.

Adinolfi, A. *and* Hopkinson, D. A. (1978). Blue sapharose chromatography of human alcohol dehydrogenase: evidence for interlocus and interallelic differences in affinity characteristics. **Annals of Human Genetics, 41,** 399–407.

Creasy, M. and Polani, P. E. (1978). High risk of Down's syndrome at advanced maternal age. **Lancet, I,** 8066, 716–717.

Klockars, M., Reitamo, S. *and* Adinolfi, M. (1978). Otogeny of human lysozymes. Distribution in fetal tissues. **Biology of the Neonate, 3,** *5–6, 243–249.*

Pembrey, M. (1978). Genetic counselling and prenatal diagnosis: what we need to know. **Modern Medicine, 23,** 2, 65.

Seller, M. J. (1978). The value of alpha fetoprotein measurements in pregnancy. **Midwife, Health Visitor and Community Nurse, 14,** 108–112.

Stanley, F. J. *and* Alberman, E. (1978). Infants of very low birthweight. I Perinatal factors affecting survival. **Developmental Medicine and Child Neurology, 20,** 300–312.

Stanley, F. J. *and* Alberman, E. D. (1978). Infants of very low birthweight. II Perinatal factors in and conditions associated with respiratory distress syndrome. **Developmental Medicine and Child Neurology, 20,** 313–322.

PASS LISTS

UNIVERSITY OF LONDON

Ph.D.—Medicine

B. J. Cohen (Medical virology)

Third (M.B., B.S.) Examination—Part I
J. M. Bailey

Third (M.B., B.S.) Examination—Part II
C. B. Archer
M. J. Margetts

Third (M.B., B.S.) Examination—Part III
M. J. Margetts

Third (M.B., B.S.) Examination—Part IV
C. B. Archer
F. J. Henderson
T. A. Underwood

Third (M.B., B.S.) Examination

Honours: N. R. Womack

Pass:
S. A. Amiel
N. C. G. Bathurst
D. L. Boone
J. Brennan
J. R. Britton
D. M. Couper
W. F. de Mello
C. M. C. P. de Sousa
D. E. Dickson
I. D. Entwisle
P. N. Gaunt
J. C. Gay
N. J. Hague
C. E. Handler
A. H. Heagerty
R. G. Henderson
A. R. Johns
R. G. C. Martin
N. J. Masters
A. L. C. Nixon
J. A. Pain
T. J. Palmer
E. Refsum
C. I. F. Rooney
P. F. Shipton
W. A. Sudell
J. S. M. Tidman
N. V. Todd
J. M. Twomey
H. Watkin
D. D. I. Wright
D. J. T. Wright

BIRTHS

HANNAFORD—To Janet and Robert Hannaford on 23rd June, 1978 at West Wales General Hospital, Carmarthen, a daughter, Jenny Elizabeth.

MARRIAGES

Peter C. S. Campion (Guy's '38–'45) *and* Margaret T. J. Reid (nee Margaret Garrett—Guy's '43–'45) married in Perth, Western Australia, on 29th March, 1978.

DEATHS

John T. Cramp, L.D.S., R.C.S. (1932) of Reigate, Surrey died on June 10th, 1978.

Walter Montgomery Smith, L.M.S.S.A., qualified at Guy's in 1930, died in Whakatare Hospital, Bay of Plenty, on April 17th, 1978.

Dr. John Rhys-Herbert, L.D.S., R.C.S., 1919, L.M.S.S.A. 1925, of Anneddwen, Barmouth, Gwynedd, died on 16.4.78.

CHANGES OF ADDRESS

Mr. P. C. S. Campion, L.D.S., R.C.S., 4/6 Onslow Street, South Perth 6151, Western Australia.

Dr. Ian V. Jones, Chief of Gynecologic Surgery, Scripps Clinic, 10666 North Torrey Pines Road, La Jolla, California 92075, U.S.A. Home.

Dr. Ian and Mrs. Jane Jones (nee Chesterfield), 1272 Santa Luisa, Solana Beach, California 92075, U.S.A.

Flight Lieutenant David and Mrs. Michèle Scott, c/o Officers' Mess, Royal Air Force Hospital, Wegberg, BFPO 40.

Dr. and Mrs. J. K. Donald, Bridge House, Pennance Road, Falmouth, Cornwall. Tel. Falmouth 312 891.

Dr. Lindsay Pritchett, Treliske Hospital, Truro, Cornwall

We should like to remind our readers that all copy for inclusion in the "Gazette" must be received 12 days before publication. Copy dates for the next 2 months are: 18th September and 16th October.

Copy may be sent to us at 16, St. Thomas Street, S.E.1.

Birth, Marriage, Death and Change of Address notices are inserted without charge to subscribers.

When subscribers notify the "Gazette" of Change of Address, would they please indicate whether or not this should be published.

Personal notices are charged at 10p per word (pre-paid, minimum £2.00).

Non-subscribers are charged £2.00 (pre-paid) for all notices other than Death.

GUY'S HOSPITAL GAZETTE

ISSN : 0017-5870 Tel. No.: 01-407 7600 Ext. 2023

EDITOR ADRIAN PINI
ASSISTANT EDITOR PHILIP RAZZELL
NEWS EDITORS STEPHEN FENNY and CAMILLA HAW
SPORTS CORRESPONDENT JONATHAN EARNSHAW
NURSING CORRESPONDENT PAMELA JEFFERIES
PHYSIOTHERAPY CORRESPONDENT RONALD COOPER
RADIOGRAPHY CORRESPONDENT JILL GUEST
MANAGER LYN PAYNE

MONTHLY 30 SEPTEMBER 1978 VOLUME 92 NUMBER 2285

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

It would be interesting for some psychologists to perform a double blind trial at Westminster to see if they could predict an M.P.'s political party. It might, I think, be a case of the blind leading the blind but I suspect that even the most adroit scientist must fail in the attempt. For all the tests would establish is that politicians are of the species Political animal. These animals need their parties, as those who have stood as independents, will endorse, for large organisations ensure the superstructure on which political power games can be played. This is well illustrated, for example, by Mr. Thorpe's frenetic clutching to his own party, by the formation of the Lib-Lab pact and by the plight of Mr. Prentice, all of whom may have to change their affiliations.

Political parties must be adopted by the electorate and some it would seem are prepared to go to almost any lengths to entice allegiance; aggressive P.R. is mandatory these days. What we are eventually sold after (subliminally?) absorbing the sop of the soap powder operas, the phallic symbolism of the cosmetics ads, the party political broadcasts or those revolting pet food commercials, is largely a matter of how good the advertising is.

And it is for this reason that the Conservatives have employed Saatchi and Saatchi *et al.*, at considerable expense no doubt, to come up with the goods for Mrs. Thatcher's election campaign. The ethics of the high pressure sell have always been somewhat suspect and it came as no surprise when the "impoverished" old lady of a recent political advert turned out to be quite alright and naturally pleased to accept her fee.

The irony is, that when the Health Education Council whose "deal" is as honest as the day is long, wants money to advertise it runs up against the stumbling block. It is a peculiar society indeed that goes out of its way to sell itself things that it doesn't really want or need.

NEWS IN BRIEF

Welcome to Guy's!

The special Freshers' Edition of the *Gazette* will be published next month but this is the first issue that new students will see. We heartily welcome newcomers to the hospital and to the ranks of our readership, and wish them every success in their studies and other fields through the coming years!

No August "Gazette"?

That's right. Due to our present financial plight no August issue of the *Gazette* was published, and we plan to combine the November and December issues as a single "Christmas Special". However, it should be noted that the *Gazette* is a fatter and more healthy-looking journal than for some time past, and we are confident that through boosting our advertising and circulation we shall produce a full twelve issues next year. In this difficult period the continuing support of our subscribing readership is more than ever valued.

Freshers' Fair

The Freshers' Fair is to be held at 5.30 p.m. in the Ballroom on Monday, October 2nd.

Each constituent club of the Union will be setting up a stall to entice the new students into participation. Various other Guy's student organisations, for example, the Christian Union and the *Gazette* will be there also.

Sing in "Messiah"

Guy's Music Club needs singers and instrumentalists for its forthcoming production of Handel's "Messiah" in Southwark Cathedral. Everyone is welcome and no auditions are required.

Please come along to the first rehearsals as follows:
Choir—Monday, October 9th, 5.30 p.m. Ballroom, Boland House.
Orchestra—Thursday, October 12th, 5.30 p.m. Ballroom, Boland House.

If you have any queries, please contact Gina Webb via the Boland House pigeon holes.

Gordon Museum soirée

Between the 2nd and 31st October inclusive the opening hours of the Gordon Museum will be extended in the evenings for the benefit of clinical medical students taking the M.B. Pathology examinations this autumn. The details are given in a notice from the Curator elsewhere in this issue. It is important to note that this scheme is experimental, and its continuance conditional on the facilities being used.

Guy's Editors

Following our report last month of Dr. W. Jackson's appointment as Medical Editorial Director of *Medicine* and our request for information about other Guy's men and women holding similar positions, we are pleased to report that Sir Cyril Clarke, F.R.S., has been Editor of the *Journal of Medical Genetics* since 1970 and Dr. Peter Pelmear has been Editor of the *Journal of the Society of Occupational Medicine* since 1976.

New Squash Courts

The new Squash Courts on the Weston Street side of the Guy's site are now ready for use. There are four courts in the building with associated changing facilities and a small viewing area.

Courts may be booked in person only in the Swimming Pool office between the hours of 10.00 and 15.00 hours, Monday to Friday up to seven days in advance, although bookings will obviously be taken for the first week from 10.00 hours onwards on Monday 18th September. During the initial period it will only be possible for the Squash Courts to be available during the hours that the Swimming Pool is open. The Courts will therefore be open from 08.20 hours to 19.00 hours Monday to Friday, 08.20 hours to 13.10 hours Saturday and the Courts will be closed on Sunday. Each session will last 40 minutes and the Courts will for a limited period of 4 weeks be open to all members of staff and students on production of the appropriate Identity Card. The charge per session will be £1 payable at the time of booking. Court bookings may be cancelled up to 48 hours before the proposed time of use in which case the Court fee will be refunded; after this period the Court fee will be retained.

Re-arrangement of Surgical Firms

Following Mr. Lawrie's retirement, the surgical firms are being rearranged as follows with effect from 1st October:

Mr. Glover/Mr. Rendall.
Mr. Beard/Mr. O'Flynn.
Mr. Maynard/Mr. Ellis.
The Professorial Unit.

An offer you can't refuse

"Join one of the élite groups of Guy's and be paid for it" writes Mr. Greenaway, secretary of the G.H.F.C. The football club needs referees for matches at Honor Oak Park on Wednesday and Saturday afternoons. Apparently only a basic knowledge of football is necessary and there is a fee of £3 per match, with food and drinks afterwards. Interested parties should contact the Football Club via the pigeon holes in Boland House.

Bermuda dental scheme

Dr. J. E. C. Weddup (Guy's 1945) has been appointed Chief Preventive Dental Officer and Project Director of a five-year comprehensive preventive scheme in Bermuda.

The results of this scheme should illustrate the feasibility of such programmes and provide information as to the health impact that can be anticipated and guidance as to cost involved. Such information will be of extreme value to small countries or territories contemplating preventive dental programmes for school children.

Special Lecture

A University of London special University lecture on Human Communication and the Problem of Stuttering by Professor Dean E. Williams (Professor of Speech Pathology and Audiology, the University of Iowa), will be held in the Tower Lecture Theatre on Wednesday, 11th October, 1978 at 5.30 p.m. Admission is free.

Dates from the Dental Diary

Monday, 1st October—Winter Term begins:
The Calendar for 1979/80 is available from Medical School Office.

Monday, 1st October

Applications for the Second B.D.S. Examination (obtainable from the Medical School Office) must be left in the Medical School Office not later than this date.

Monday, 8th October

Applications close for the Third B.D.S. Examinations, Parts I, II, III, IV and V.

Monday, 8th October

Applications close for the Second B.D.S. Examination.

Monday, 15th October
Entries close for the Prize in General Subjects Examination.

Monday, 15th October
Prize Examination in Children's Dentistry, including Orthodontics begins

Thursday, 18th October

Applications for the Final L.D.S. Examination, Parts I and II (obtainable from the Medical School Office) must be left in the Medical School Office not later than this date.

Monday 22nd October

First L.D.S. Examination begins.

From the Medical Diary

Monday, 8th October

Final M.B., B.S. (Old Regulations) Examinations begin.
Entries close for M.B., B.Chir. (Cambridge) Examinations.

CLUBS' UNION NEWS

Physiotherapists and Radiographers Rejected

At the last meeting of the School Governors a proposal that the physiotherapy and radiography students in the hospital be given associate membership of the Clubs' Union was considered. Besides the freedom to use the facilities as members presently do, they would be co-opted onto the organising committees of the Union and its Clubs and so participate in all the Union's activities except voting at General Meetings or elections.

The student members of Clubs' Union Council are unanimous in their support for this proposal. They felt that:

> *"Wolfson House has added immensely to the social life at Guy's—very much a 9.00–5.00 college, many activities now occur in the evening. Besides the 200 medical and dental students in Wolfson House there are some 50 physiotherapy and radiography students who live there. But they are at present not able to use the same social and sporting facilities with ease. It is difficult as a student physiotherapist or radiographer to get involved in the life at Guy's.*

To bring these students into the Clubs' Union and involve them in the activities of the Union be they drinking, dancing or sporting will add immensely to the community spirit among the students at Guy's, at present fragmented and faltering. Virtually all the students are about the same age and they have many interests in common, interests which if brought together and encouraged to flourish can only add to the life at Guy's to the benefit of all concerned."

But the Governors disagreed and the proposal was turned down. Lord Robens replied:

"After careful consideration the Council agreed unanimously that the proposal cannot be accepted. The School Governors, who are responsible for the School, are not responsible for the Physiotherapy and Radiography students and are not disposed to alter the present arrangements for Clubs' Union membership. However, they are more than happy that the facilities of the Clubs' Union premises may continue to be enjoyed by Guy's Physiotherapy and Radiography students and Nurses on the present courtesy basis."

One can only speculate as to the reasons why the proposal was declined; perhaps they were legal:

"The Clubs' Union is legally a part of the Medical School and as such enjoys charitable status, like every other Student Union in the country. The School is a University institution and to bring into the Clubs' Union non-university students could endanger the charitable status of the Clubs' Union and perhaps also of the School.

There is no definitive legislation on this point. The most important case on this subject is that of the London Hospital Medical College v. Inland Revenue Commissioners and Another in 1976. This case tested the purposes of the Clubs' Union and it was ruled by Judge Brightman that the Clubs' Union's activities were an essential part of the educational purposes of the Medical College and thus charitable.

We, in the Clubs' Union maintain that the introduction of physiotherapy and radiography students into the Union would promote the educational purposes of the Clubs' Union—in a different but analogous way to the qualified staff being life members of the Union. Therefore although it might seem that non-university students in a university institution could endanger its charitable status; in fact, we hold the opposite to be the case—if these other students are not members, the educational purposes of the Clubs' Union are limited to an undesirable extent and to the detriment of the members of the Union and the Hospital."

Or maybe there were financial considerations beyond our comprehension.

"University Grants Committee policy allows non-university students to use university facilities as long as that use is reflected in the contributions paid towards the facilities by the non-university students.

The Clubs' Union has two principal sources of income. The first is the capitation fee (£25) levied from the Local Education Authorities along with the tuition fees. The second is the subvention from the School paying the running expenses of Boland House and of the other Union facilities."

The D.H.S.S. already pays membership fees for other paramedical students and an associate membership fee of £10 would not be considered very much. And the hospital might well be prepared to pay towards the running expenses of Boland House for some of their students who have almost no facilities of their own.

So, dear Governors, wherein lies the problem. You have said "No", but your reasons are not clear. Are we too young and naïve to comprehend the depths of your decision or is it that the depths of your decision are unclear to all?

David Denning.

Appreciation

DR. IAN MACKENZIE

Ian Carvill Keith Mackenzie studied medicine at Cambridge and Glasgow, where he qualified in 1938, and after holding a House Surgeon appointment at the Victoria Infirmary he was on active service with the R.A.M.C. from August, 1939 until January, 1946, being subsequently awarded the Territorial Decoration. After the War he resumed his interrupted career and following appointments as House Physician and Medical Registrar in Glasgow he decided to devote himself to neurology and spent the years 1948–51 as H.P. and then R.M.O. at the National Hospital for Nervous Diseases, Queen Square. In March, 1951 he became Chief Assistant to the Neurological Department at Guy's and in 1955 he succeeded Sir Charles Symonds as consultant neurologist.

He was fortunate in having these years of association with Symonds, for there was an affinity between them in their approach to neurology which was very fruitful and although to follow the most distinguished neurologist of our time was no doubt a daunting prospect in the event he proved to be a very worthy successor and both his patients and colleagues have reason to be grateful for the outstanding service he has given to Guy's. He was the first of our neurologists to hold consultant sessions in the Region as well as at Guy's and this proved to be a very happy association, providing a first-class neurological service to the Maidstone district and enabling him to teach at both undergraduate and postgraduate level on the wide variety of patients transferred to Guy's for further investigation. He has always enjoyed excellent relations with his colleagues both senior and junior and the high respect in which he has been held is shown by the many former registrars, now consultants, who have continued to turn to him for help over difficult problems.

Essentially a clinician, he has not been a prolific writer but his study of the clinical presentation of cerebral angioma was a major contribution to the subject and his method of testing taste by electrical stimulation has stood the test of time. He has been responsible for the neurological sections of several editions of both French's "Index of Differential Diagnosis" and "A Short Text Book of Medicine".

We wish him a long and happy retirement.

J. C. Houston.

OBITUARIES

Dr. Frederick Charles Endean

Frederick Charels Endean, the fourth son of John and Ellen Endean, a well-known pioneer family in Auckland, New Zealand, died on August 28th, aged 96 years and 10 months.

He was the first New Zealander to qualify as a pharmaceutical chemist at the age of 19.

In 1910 he qualified M.R.C.S. at Guy's Hospital. He was Resident Surgical Officer at St. George's Hospital and later at St. Peter's Hospital for Stone.

On August 4th, 1914, he volunteered for the Royal Navy serving throughout the war to 1919. During the last critical period of the war he was in charge of all Genito-Urinary Wards of the Royal Naval Hospital, Plymouth, where he did such valuable work in rehabilitating crews for the fighting ships that he was recommended for the O.B.E. This he declined on the grounds that he had only done his duty. He was nevertheless mentioned in despatches.

While at the Royal Naval Hospital, he successfully performed the first homograft on an Australian volunteer ordinary seaman, the prepuce skin graft having been taken from a boy trainee from H.M.S. *Impregnable.* In 1917 this was a brilliant *tour de force,* plastic surgery not being his speciality.

In 1920 he joined the staff of the West London Hospital, Hammersmith, becoming the first director of the special Clinic where he did further valuable work pioneering the treatment of the venereal diseases. On retiring he became Honorary Consultant to the Hospital.

Throughout his medical career, he maintained an extensive private genito-urinary practice in partnership with the late Sydney Macdonald and then on his own account until he retired from Harley Street at the age of 82.

A man of extraordinary vigour and fine clinical acumen, he was much loved by medical colleagues and his patients.

He is survived by his daughters Marie Grace Endean, M.A.Lond., and Joan Endean who qualified M.B.,B.S., at Guy's Hospital in 1953.

Marie Grace and Joan Endean.

Dr. Arthur Roland Phillips

It is sad to relate the death of Roly Phillips at the early age of 53 years after a short illness in hospital.

He came to Guy's from Mill Hill in 1943 when the Medical School was still evacuated to Pembury.

The return to the Borough, the end of the war and the relaxation of constraints all tended to make one's studentship in those days an enjoyable and memorable time. Roly Phillips was very much part of that scene and contemporaries have had many a happy evening reminiscing on those days.

He played regularly for the "A" XV until, with a number of us from the Old Hostel, he joined The Tankards XV.

He qualified M.B.,B.S. in 1951 and was appointed House Surgeon at Queen Mary's Hospital, Sidcup. In November that year he married Lois Wooley who was Sister on Astley Cooper.

In 1952 he joined the R.A.M.C. on his National Service and so enjoyed the life that he took a regular Commission. He rose to the rank of Lieut. Colonel and, during his army career was, for a time, Senior Medical Officer, H.Q. Command, S.H.A.P.E.

In 1965 he passed the D.T.M. & H.(Eng.).

Retiring from the army in 1971, he entered general practice at Bexhill-on-Sea where he rapidly gained a reputation for kindness, patience and friendliness which encouraged his patients to regard him both as physician and family friend.

His contemporaries will remember him with affection and we extend our sympathies to his wife Lois and his children, Simon, Greta and Mark.

J. S.

Dr. Gray Mathewson

Dr. John Gray Mathewson died in Fleet Hospital on September 5th. He was in general practice in Fleet from 1947 to 1973, after serving during the war in the R.A.F. He was educated at Downside, Pembroke College, Cambridge and Guy's. While at Guy's he was Resident Medical Officer to Nuffield House, Clinical Assistant in the Neurology Department and Neurological Physician to Sir Charles Symonds. He was very attached to Guy's and when eventually he became a patient in Guy's under Dr. Richard Hughes and Mr. Polkey he was happy to be in the surroundings and with people who were part of his younger days. For this his wife, son and daughter will always be grateful.

W. B. O. Maile.

UPS AND DOWNS OF ASTHMA

by G. M. Cochrane, BSc, MB, MRCP

Consultant Physician, Guy's and Lewisham Health Districts

(Graphics by S. W. Lewis, BSc

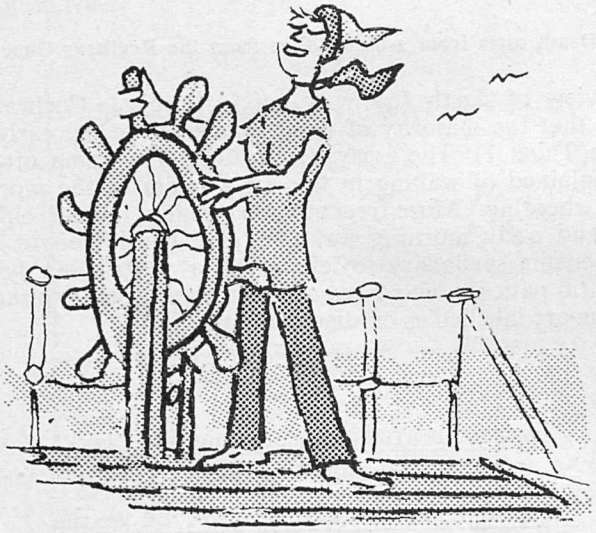
Medical Student, Guy's Hospital)

From a lecture given to General Practitioners' Course.

Asthma has been considered to be a non-lethal disease affecting all ages and sexes and many patients who suffer from asthma are considered either neurotic or individuals who lack "moral fibre". Since 1867, when Registrar General Statistics were introduced, there has been a significant death rate from asthma which has changed little over the last hundred years. This is despite the introduction of many new drugs (adrenaline, ephedrine, corticosteroids and later isoprenaline), and in the view of other countries the introduction of isoprenaline is itself associated with an increase in the death rate (Fig. 1).

The Pearl Girl Endowment Policy

with options on marriage



The PEARL GIRL *policy is specially* designed for the young lady who expects that one day she will marry (it also provides attractive benefits should she remain single).

Face the future with confidence

SEND TODAY FOR OUR INFORMATIVE LEAFLET

PEARL ASSURANCE COMPANY LIMITED

Chief Office: High Holborn, London, WC1V 7EB

Cover yourself with Pearl assurance

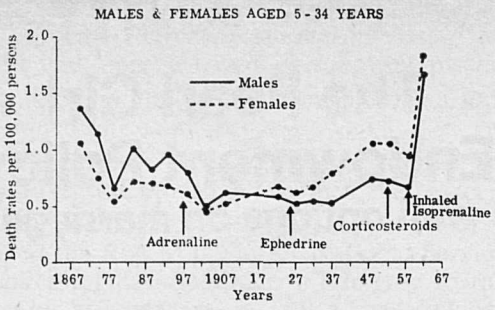


FIGURE 1. Death rates from asthma taken from the Registrar General's statistics.

In a review of death from asthma in hospital, Cochrane and Clark (1975) noted that the majority of deaths occurred in the early hours of the morning (see Table 1). The early descriptions of asthma often noted that patients complained of waking in the early hours of the morning short of breath and wheezing. More recently, especially in the elderly patients, orthopnoea and early morning wakening are considered to be caused by pulmonary oedema secondary to left atrial or ventricular dysfunction and many asthmatic patients who have a dip in their peak expiratory flow rate in the morning are labelled as cardiac patients.

ASTHMA DEATHS (Cochrane and Clark)

Time after admission	No. of deaths
0-2 days	7
2-7 days	6
7-14 days	3
14 days	3
Midnight - 0800	13
0800 - 1600	3
1600 - Midnight	3

TABLE 1. Time after admission and time of death during the day in patients dying from asthma—taken from Cochrane and Webb, 1975.

Patterns of Asthma

Asthma, by definition, is associated with spontaneous variability of airflow obstruction and approximately 2% of the population suffer from significant broncholability. The aetiology of this broncholability and the biochemical and immunological mechanisms associated with asthma are ill understood and outside the scope of this article but a number of factors associated with either circadian variation or induction of bronchoconstriction will be discussed.

Diurnal Variation

Many patients with asthma are seen in clinic during the morning or early afternoon when their peak flow measurement, when related to the predicted value, is normal. There is an immediate tendency to consider the patient's complaints of breathlessness on rising or during the night as to be "of the mind" rather than of the airway, but by taking a careful history and by supplying the patient with a peak expiratory flow meter to determine his own peak flow at home, a diurnal variation in PEFR is often determined (see Fig. 2). Patients with asthma often note wheeze on rising which clears spontaneously, especially with the indirect effect of caffeine (methylxanthine) on both the airways and adrenal medullae and by mid-morning the patient is well and symptom free.

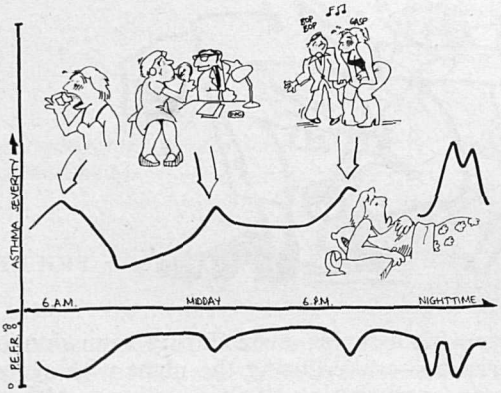


FIGURE 2. A day in the life of a patient with asthma.

Large meals at lunchtime or the ingestion of food allergen (though rare) (Fig. 3), can lead to a fall in PEFR during the afternoon, but usually —unless another precipitating factor is met—the PEFR is maintained during the afternoon and slowly falls during the evening. The patient rarely notices any wheeze or tightness at this time. The reasons for not noticing this fall in PEFR, which may be as much as 25%, are not understood. They could be associated with both the minimal stressing of the system at this time of day and also the lack of awareness in changes in PEFR if these take place over hours rather than minutes (Webb and Cochrane, unpublished). At any time during the day a period of intense exercise, e.g. running for the bus, may be associated with a sharp fall in peak expiratory flow rate, with tightness of the chest (overinflation secondary to gas trapping on expiration) wheeze and breathlessness. This exercise induced asthma (EIA) is always greatest following running and least following swimming, while bicycle riding, either in the laboratory or as a means of transportation, involves a degree of EIA between running and swimming. The mechanism for exercise induced asthma is poorly, if at all, understood, and the obvious candidates such as hyperventilation, hypocapnia and acidosis cannot be considered as causative mechanisms. An attractive hypothesis is that the macrophages of an individual with EIA are more sensitive to vibration, and the degree of EIA is "vibration induced". Unfortunately running downhill (a far more jarring sport) produces less EIA and whole body vibration has no effects in

most patients with broncholability. Exercise induced asthma is prevented by stimulant drugs and often prevented by disodium cromoglyate, but not corticosteroids.

FIGURE 3. Yeast allergy.

Many patients with asthma—even during remission or with well controlled diurnal variation—wake during the night with symptoms which may be attributable to an exacerbation of their asthma. Although not always a catastrophic attack of wheezing and breathlessness, the patient may wake with a dry cough (often a symptom which is not attributed to asthma but relieved by the inhalation of a β_2 adrenergic stimulant) or mild shortness of breath. This persistent waking at night is often an accepted way of life and only when affecting a spouse or partner is it realised to be abnormal by the individual with broncholability. As you can see (Fig. 2) a day in the life of many subjects with asthma is associated with marked variability in symptoms with corresponding loss of enjoyment of life.

Possible Mechanisms for the Early Morning Dip in PEFR

1. Allergens

A proportion of patients with asthma showing diurnal variation on prick testing, show a positive Type I reaction to house dust and the house dust mite (*Dermatophagoides pteronyssimus* (Fig. 4). With the accepted correlation between Type I prick tests and bronchial challenge, it would not be surprising if the fall in peak flow at night was associated with the considerably greater contact with this allergen on retiring to bed. The average individual sleeps with 200–300 mites/night, a count often increased in young children with soft toys where the mites hibernate during the day. However, the majority of intrinsic asthmatic patients have a similar diurnal variation. It is unlikely that exposure to a particular allergen leads to the spontaneous diurnal variation often seen in such patients. Obvious provocation will, however, induce an attack, such as

taking aspirin-containing compounds in certain individuals or emptying a hoover bag in a house dust sensitive individual.

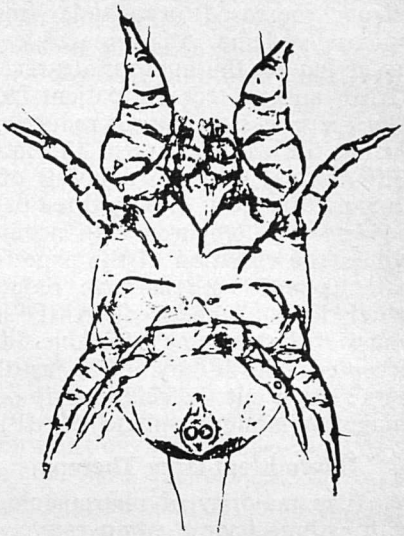


FIGURE 4. *Dermatophagoides pteronyssimus* (house dust mite).

2. **Posture**

A unifying characteristic of sleep is posture and perhaps the nocturnal variation in symptoms and peak flow is associated with this. Despite being an attractive theory with a number of pseudo-plausible physiological explanations this does not appear to be the mechanism, as Clark and Hetzell (1977) have altered the posture of patients with asthma and have shown diurnal variation in peak flow whatever the position, be it recumbent or vertical.

3. **Circadian rhythm of the Hypothalamic Pituitary Axis (HPA)**

The well documented acute response to corticosteroids in the PEFR of both intrinsic and extrinsic subjects with broncholability has suggested that a low level overnight of circulating corticosteroids, a pattern which occurs in all people, may lead to an increase in airflow obstruction. Work by Soutar (1975) has not shown any greater variation in circulating corticosteroid level in broncholabile subjects, and high dose cortisol intravenous infusion did not obliterate the diurnal variation. A more elegant refutation of this suggestion has been the work of Clark and Hetzell (1977) where subjects susceptible to marked diurnal variation in PEFR who worked day and night shifts, were asked to record their PEFR before and after changing from day/night to night/day shifts. The change in diurnal variation of PEFR occurred on the day of the working shift change whereas HPA changes in circadian rhythm take 2–3 days to occur.

4. **Sympathomimetic amine Excretion**

The suggestion that patients with asthma have reduced levels of cyclic AMP in leucocytes and reduced urinary excretion of catecholamine metabolites started interest in the sympathomimetic activity of such patients. Cyclic

AMP levels are considered to be a second messenger in the protection against initiating the chain reaction leading to the release of mediator substances (bradykinin, histamine and slow release substances). All are considered to trigger increased bronchiolar muscle tone, mucous hypersecretion and mucosal oedema. An increased level of circulating sympathomimetic amines by action on the appropriate receptor should lead to an increased level of cAMP and protect the patient from bronchoconstriction. Soutar suggested that there was an overall reduction in circulating sympathomimetic amines during the early hours of the morning of patients with asthma compared with normal subjects. Anaylsis of his data from several subjects does not support this view; in only three patients could a distinct reduction in amines be detected compared with normals, and the degree of reduction is well within the variation of the experimental technique. Although the idea that patients with asthma have reduced sympathomimetic activity overnight, which leads to reduced cAMP and bronchoconstriction during the early hours of the morning is tenable, this needs more clear cut proof before being accepted. Also it may not be just the level of cAMP which leads to bronchoconstriction but the relationship or ratio between levels of cAMP and cyclic guanosine monophosphate (cGMP).

5. **Intermittent Drug Therapy**

The majority of pharmacological preparations prescribed for patients with asthma have a comparatively short therapeutic effect (4–6 hours) and are usually administered four times a day. Therefore the appearance of symptoms 6–8 hours after the last therapeutic attack (10–11 in the evening) may not be a surprise. This allied to the previous comment regarding the awareness of bronchoconstriction and bronchodilation being related to the rapidity of onset may account for the waking in the early hours of the morning, with rapidly falling therapeutic blood levels of prescribed drugs. Against this argument is the new undiagnosed patient whose history of disturbed sleep rhythm associated with wheeze and breathlessness has not been affected by the physician's therapeutic attempts. However, "pulsed" therapy with β_2 stimulants, where the time between therapy has progressively been increased, has suggested that there is an increase in symptoms (and corresponding fall in PEFR) overnight when therapy is omitted earlier in the previous evening. As will be discussed later, slow release preparations have been produced to avoid this effect of pulsed therapy.

The mechanisms associated with diurnal variation in symptoms and PEFR in patients with asthma are not understood and require further investigation.

Management

Management of patients with asthma can be both rewarding but also difficult. Correct treatment relies on the correct diagnosis, assessment of the patient's pattern of asthma and development of a liaison with the patient. Like the diabetic, he should be adequately informed and active in his own assessment and management.

Diagnosis

This is normally easy when the patient is young and presents with a story of paroxysmal breathlessness and wheeze, often with seasonal variation and hay fever and/or eczema. Unfortunately, in the more elderly patient the story is less clear, and in patients where diagnosis is difficult the loan of

a simple peak flow meter and a diary card often shows the semantic hallmark of asthma—variability of peak flow. However, in all patients with evidence of serious airflow obstruction a brief trial of corticosteroids should be tried: the usually recommended dose being 30–40 mg/day. Unpublished data by Webb has shown that if there is a response it will have reached a maximum by the tenth day, and therefore a 10–14 day trial is all that is required. Stopping the steroid abruptly after two weeks is unlikely to cause serious problems unless a major stress episode occurs in the first 2–3 days (Webb, J. R.).

Assessment

During the initial assessment possible allergic factors should be investigated both for industrial and domestic exposure. House dust mite sensitivity is common and although environmental control of dust is encouraged it is unlikely that these measures will reduce the mite population to an extent where the patient will have no symptoms. Hyposensitisation has been suggested for house dust mite allergy but evidence regarding its efficacy is limited and further desensitisation preparations are being developed and studied. Marked seasonal symptoms associated with positive prick testing to grass pollen have been treated by hyposensitisation with success and are commonly recommended in this country as elsewhere (Lichenstein, 1978).

In the patient with multiple allergies and raised total IgE and specific IgE, desensitisation and environmental control are unhelpful. In the group of patients, usually female and in the older age group, no allergen is normally detected and IgE levels are within normal range. Like all patients with asthma they tend to have both a blood and sputum eosinophilia (intrinsic asthmatics).

Treatment

Patients with acute severe asthma should be admitted to hospital; the severity of their asthma being determined by clinical grading of their exercise tolerance, pulse rate, pulsus paradoxus and dramatically low (<150 l/m) peak expiratory flow rate. Further discussion of this group is outside the scope of this article. Treatment of patients with asthma can be crudely divided into four groups on a historical basis:—

1. **Patients with mild symptoms often related to activity and with occasional nocturnal wakening or early morning breathlessness**

These patients often respond to sporadic bronchodilator aerosol use when they have symptoms as before activity such as housework or games. There are many selective β_2 stimulants aerosols available and these should be preferred to isoprenaline on both grounds of possible safety and also a longer duration of action. Patients should not be banned using these aerosols but educated in both the correct inhalational technique and also to use the frequency of using them as an assessment of the severity of their asthma. Patients should be encouraged to seek advice if they require more than ten puffs of the aerosol to control their symptoms as, if previously well controlled on the occasional use of the aerosol, this increase is a sign of an exacerbation.

2. **Persistent symptoms throughout every day in subjects with positive skin tests**

These patients are often helped by using disodium cromoglycate initially in a dose of one capsule four times a day, which may be increased to two

capsules four times a day. Ideally peak flow should be recorded three times a day during the trial of this drug along with a diary card to determine efficacy with at least one week as pre-trial control period. "Intal Co" containing both disodium cromoglycate and isoprenaline should not be used, as any improvement may be associated more with the regular isoprenaline treatment than the disodium cromoglycate. The addition of β_2 stimulant aerosol two puffs four times a day in a patient with a partially successful trial of disodium cromoglycate can be useful, and if taken before the disodium cromoglycate may prevent the occasional bronchoconstriction associated with this preparation from occurring.

3. Patients with persistent symptoms

Whether an intrinsic asthmatic or one who has significant symptoms, despite a trial of disodium cromoglycate, should be tried on steroid aerosol four times a day. Again partial response in PEFR and symptoms with regular steroid aerosol use may be improved by the addition of regular bronchodilator. No mention has been made of oral preparations as inhaled preparations should be used if at all possible.

Asthma has not only a diurnal variation but in many patients a spontaneous variation over months and years, so when patients in the first three groups have few symptoms from their asthma the regularity of drug taking will fall. The doctor should encourage the patient to be the master of his own therapy and to learn to be able to treat his own asthma. The majority of diabetics run their own therapy and are helped by regular urine testing, so by analogy if the patient with asthma measured his own PEFR on a regular basis, accurate assessment and control could be managed by the patient. This is no longer a dream as adequate peak flow meters are available costing less than three months' supply of disodium cromoglycate.

4. Patients with severe persistent symptoms

These patients should be given a trial of steroids outlined previously with careful monitoring of the PEFR. Failure to respond to a trial of steroids in a patient believed to have asthma should suggest either a diagnostic error or the requirement of hospital admission. Many patients following a good response to corticosteroids require little or no treatment and normally I stop the steroids and follow the patients. A number will fall into a category described above and will respond to the appropriate therapy. The indications and efficacy of long term corticosteroid therapy are open to discussion but fortunately the number of patients who require such a regime is small.

The problem of nocturnal symptoms remains; often easily solved by a "couple of quick puffs" at three a.m. More recently both β_2 stimulants and methylxanthine preparations have been produced in oral slow release preparations. These have been shown to work well in a few patients, but have the problem of oral preparations in the increased incidence of side effects compared with inhaled preparations. Slow release methylxanthine (Berry and Cochrane, unpublished) do not maintain therapeutic levels for the necessary ten hours without having a highly toxic initial blood level. More work is required to determine therapeutic regimes to prevent the early morning dips. However, the remaining diurnal variation in symptoms and PEFR can be controlled in many patients.

DENTAL SURGEON

LIBYA SALARY c. £11,000 Net

Our Client, the Oil Industry Medical Society, provides medical and dental services for employees and dependents of major companies engaged in the oil industry at its modern hospital in Tripoli.

A vacancy now arises for a dental surgeon to join two others and a full-time hygienist in the well-equipped dental department. Responsibilities will consist of providing routine dental care to members and their dependents.

The starting salary and overseas allowances will depend on experience, qualifications and domestic arrangements but will not be less than £11,000 net. Up to 90% of salary may be remitted abroad.

Furnished accommodation will be provided. Personal effects may be shipped to Libya at Society expense and thirty days paid home leave is provided annually for employees and families with free return air passages. Also there is local leave of 15 days. Generous educational assistance is provided for children and there are other benefits.

The initial contract is for two years and is renewable annually thereafter.

Applicants should write, in complete confidence, giving career details and quoting reference LIBYA/FR to:

F. Rothwell C.B.E., Whitehead Technical Services Limited, The Whitehead Consulting Group, 21 Wigmore Street, London W1H 9LA.

1974

WHITEHEAD

SUMMARY

Asthma is defined in terms of variable airflow obstruction and this variability may be monitored by measuring peak expiratory flow rate. Diurnal variation in PEFR occurs in most patients with asthma. There is an incidence of death from asthma—a high proportion of these in the early morning; a time when PEFR is lowest even in the well asthmatic. The cause for the early morning dip is unknown but may be decreased by greater control of the day time symptoms.

Guidelines to the management of patients with asthma have been suggested using regular assessment with diary cards, and in particular peak flow meters, as the patients' subjective assessment of the severity of their asthma is poor.

The use of peak flow meters by patients with adequate explanation of their drug therapy is suggested so that patients with asthma may, like patients with diabetes, greatly improve their own day to day care.

REFERENCES

BERRY, D. and COCHRANE, G. M. (1978) Serum theophylline levels in normal subjects taking oral slow release theophylline (in preparation).

COCHRANE, G. M. and CLARK, T. J. H. (1975) A survey of asthma mortality in patients between ages 35 and 64 years in Greater London Hospitals in 1971. Thorax, **30**, 300.

CLARK, T. J. H. and HETZEL, M. R. (1977) Diurnal variation of asthma. Brit. J. Dis. Chest, **71**, 87

LICHENSTEIN, L (1978) An evaluation of the role of immunotherapy in asthma. Am. Rev. Resp. Dis., **117**, 191.

SOUTAR, C. A., COSTELLO, J., IJADUOLA, O. and TURNER WARWICK, M. (1975) Nocturnal and morning asthma, relationship to plasma corticosteroid and response to cortisol infusion. Thorax, **30**, 436.

SOUTAR, C. A., CARRUTHERS, M. and PICKERING, C. A. C. (1977) Nocturnal asthma and urinary adrenaline and noradrenaline excretion. Thorax, **32**, 677.

WEBB, J. R. (1978) Corticosteroid trials in chronic airflow obstruction (in preparation).

WEBB, J. R. and COCHRANE, G. M. (1978) Awareness of change in PEFR related to the rapidity of this change (in preparation).

THE HEALTH EDUCATION COUNCIL AND ITS WORK

by George Cust

Chief Medical Officer, Health Education Council

Health Education

Health Education is one of the tools of preventive medicine. Its purpose is to increase people's knowledge and understanding of health and disease so that they may make informed decisions about their personal health behaviour so leading to the prevention of disease. Area health authorities employ specialist staff, Health Educations Officers, who co-ordinate, organise and advise on health education at local level. Health education in schools is another important part of health education.

The Health Education Council is a central organisation which carries out health education at national level and co-operates closely with area

health authorities and local education authorities. The H.E.C. was set up in 1968 on the recommendation of the Cohen Committee (1964), a joint committee of the Central and Scottish Health Service Councils. Though the funds of the H.E.C. come from the D.H.S.S. it was set up as a private independent company. This was done so that the organisation though having close links with central government "would be freer to experiment, to adopt unusual courses and to take risks". I doubt if a department of state would have produced this "brewers droop" advert, which the H.E.C. used as part of an anti alcoholic programme in Tyne Tees.

The Council

The Council consists of 26 members appointed by the Secretary of State for Health and Social Services from men and women of distinction in medicine, education, dentistry, nursing, journalism and public office. The Chairman is appointed by the Secretary of State.

Functions

The functions of the Council are:—

(a) To advise on priorities for health education on the basis of the best information available.

(b) To advise and carry out national campaigns, and local or regional campaigns in co-operation with regional and area health authorities and local authorities as appropriate.

(c) To produce information and publicity material in support of national and local campaigns and of such other activities as the Council may undertake; and to make such material available to area health authorities, local authorities and voluntary and other appropriate bodies.

(d) To undertake or sponsor research and surveys designed to ensure that reliable and up-to-date information and statistics are available on which to base the campaigns and other activities of the Council.

(e) To seek advice and to review relevant medical, epidemiological, sociological, psychological and other information available and as necessary, to undertake or sponsor research and surveys designed to obtain such information, to assist the Council in its determination of priorities and its measurement of the effectiveness of the results of its national and experimental campaigns.

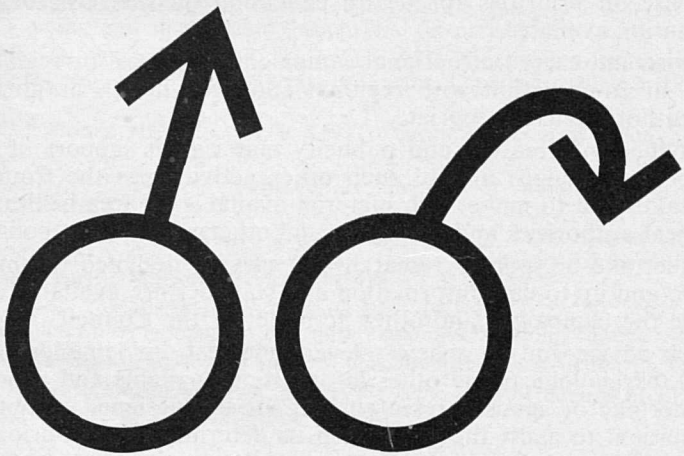
(f) To act as the national centre of expertise and knowledge in all aspects of health education so that advice is available at all times to area health authorities and others engaged in health education; and, with the agreement of the National Health Service and local authorities, educational and voluntary bodies, to co-ordinate health education activities where appropriate.

(g) To encourage and promote training in health education work; and to provide to other bodies advice and guidance on the organisation and content of courses of training together with such practical help as may seem appropriate and within the resources of the Council.

(h) To co-operate with local education authorities, educational establishments and the Schools' Council in the development of health education in schools, colleges and polytechnics.

(i) To maintain contact with national voluntary bodies engaged in particular aspects of health education work; and to give aid and advice to such

If you drink too much there's one part that every beer can reach.



Your health isn't the only thing which suffers if you over-drink. A night of heavy drinking can make it impossible for you to make love.

And even if you think your drinking isn't affecting you, have you ever wondered how it might be affecting your partner?

Put it this way. How would you like to be made love to by a drunk?

The Health Education Council. **Everybody likes a drink. Nobody likes a drunk.**

If you think you have a drink problem, see your doctor or contact the North East Council on Alcoholism, Mea House, Ellison Place, Newcastle upon Tyne NE1 8XS. Tel: Newcastle upon Tyne 20797.

bodies as appropriate and to the extent that the resources of the Council permit.

(j) To publish material of interest and value to those engaged in health education.

The H.E.C. covers England, Wales and Northern Ireland. A similar but separate organisation, the Scottish Health Education Unit, was set up in Scotland.

Resources

To carry out these functions, the Council had, in 1978, a budget of £3,080,000 and a total staff of 65. The finance is provided by the D.H.S.S. and since the Government has in recent years accepted prevention as one of its health priorities the budget has increased considerably; from £100,000 in 1968–69, £1,000,000 by 1974–75 to its present level of £3,000,000. This is to be compared to the total spending on all health and personal social services of £7,670,000,000 in 1977–78, and is in no way sufficient for the tasks which it has to do. Health behaviour is slow to change and short term health education programmes only lead to short term results. For permanent changes in health behaviour, education must be sustained over long periods of time. As the Council takes on long term tasks, programmes on non-smoking, promoting exercise, on diet, self care and against alcohol abuse, the programmes need sustaining over years and their costs become cumulative.

Campaigns

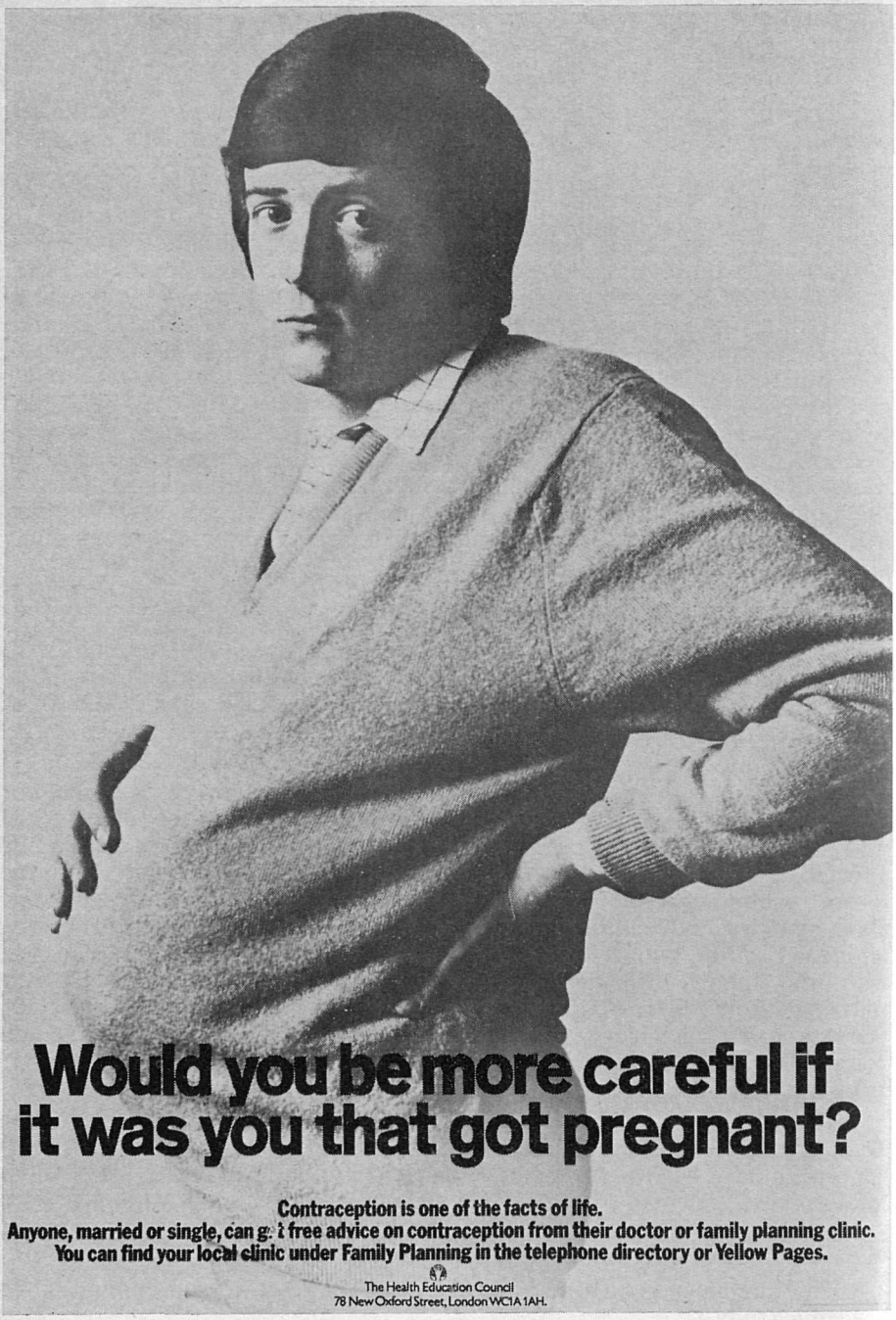
The work of the Council is probably best known to the public by its mass media campaigns. Because of its relatively small budget the Council has promoted high impact sometimes abrasive "the pregnant man"; "the nude pregnant women"; "I hope he's careful" advertising to reach its target audience.

By using a number of carefully integrated adverts on T.V. radio and national newspapers, with local support by health education officers and with support from health care professionals, the public can be reached and affected. The Council, though limited by lack of funds in comparison to the tobacco manufacturers, has, in most years, had some mass media campaign about smoking and health. Evaluation shows each of these campaigns having an impact on the knowledge and attitudes of the public. Over the years and with other inputs, from the Royal College of Physicians with its reports on smoking; the work of ASH; programmes on the mass media and the additions to basic knowledge given in school; the sales of cigarettes in this country has fallen from 243.1 million lbs. in 1961 (year of peak sales) to 197.8 million lbs. in 1977—a fall of 18%.

The "Look After Yourself" campaign, which the Council started in 1978, promoting exercise and staying slim, and which will continue, already appears to have been a success in catching the public's interest. Tremendous local support has come from A.H.S.'s and other organisations who have been promoting exercise classes, slimming classes, etc., at local level, an example of the multiplier effect which we try to achieve.

This campaign is being evaluated by market research surveys and by an academic study.

An experimental campaign in the Tyne Tees T.V. area to try and promote the health education concepts in the Report of the Advisory Committee


Would you be more careful if it was you that got pregnant?
Contraception is one of the facts of life.
Anyone, married or single, can get free advice on contraception from their doctor or family planning clinic.
You can find your local clinic under Family Planning in the telephone directory or Yellow Pages.
The Health Education Council
78 New Oxford Street, London WC1A 1AH.

on Alcoholism Prevention, started in November, 1978. A previous short term campaign in 1974, in the same region, showed short-lived positive changes in attitudes and over 1,000 people reporting for advice and counselling over this short period of time (Cust, G., 1978). The present campaign, it is hoped, will run for a number of years and there are signs of changing attitudes in the desired direction.

The Council has supported a programme informing young people about contraception since 1968. This programme to increase knowledge and a sense of responsibility among young people, together with the free family planning service must have played a part in the reduction of pregnancies conceived outside marriage which have decreased from 36.7 per 1,000 unmarried women in 1970 to 30.8 in 1975 (Edmunds and Yarr, 1977).

Other campaigns include Smoking in Pregnancy; an experimental campaign to reduce the incidence of head lice infestation; a campaign each winter, "Cold kills the old" to reduce the incidence of hypothermia on the elderly.

School Health Education

Health education in schools is another long term priority. One of the Council's basic policies is that the teacher is the most important health educator in schools and in co-operation with local education authorities, promotes health education in school. The Council has promoted research work on the needs of health education in schools and encouraged the development and trials and dissemination of curriculum projects in health education. Financial assistance has also been given to a joint project with the Schools Council on curriculum development in health education.

Curriculum and training of health educators

There are three priority areas as seen by the Council. First to promote the education and training of health education officers. Health education officers hold appointments within the N.H.S. at Area level and are responsible for providing a consultancy and resource service and for co-ordinating the educational effort towards health within their area. They come from a variety of professional backgrounds, particularly nursing and teaching. To provide a training experience of some length and depth, the H.E.C. has helped develop a full time one year course leading to the Diploma in Health Education. There are now two centres, at Leeds (commenced 1972), and at London (commenced 1975) and they can take together forty-two students each year. There are currently 304 health education officers of whom about two-thirds do not yet have a Diploma. For health education to develop satisfactorily at local level there is need for about 1,000 health education officers in 10 years time. There will be a need for a third Diploma course soon, probably in the west of the country. To help A.H.A.s develop trained staff the H.E.C. has borne two-thirds of the costs of the training, but has required an undertaking from the A.H.A.s that a supported candidate would return to a health education officer's job. Twenty-two such students are on Diploma Courses in 1978–79.

The second priority has been the setting up of a network of courses within established educational institutions like polytechnics and colleges of technology of courses to assist health workers whether in the health service

or local authority to understand better the nature of the educational process and to become better at enabling the people with whom they come into contact to learn from them. There are now eighteen of these courses running regularly training some 270 health professionals each year in the method and practice of health education. Run on a part-time basis they take up the equivalent in time of thirty-six days. The Council, with the institutions concerned, issue a certificate in health education to successful students.

The third priority has been to try and extend the academic base of health education by the development with two medical schools and one faculty of education of masters degree courses.

Research

The Council has always clearly seen the need to add to the research-based, core knowledge of health education. It spends 5% of its budget on research projects by accepting proposals from individuals and institutions. Current or recently completed work includes investigations into Alcohol in teenage culture; Impact of the mass media on health behaviour; Dental health education in schools; Early reporting of heart attacks; The first year of motherhood; Evaluation of a booklet on the management of minor illness, a study to assess the effectiveness of a school health education programme about smoking for primary school children; Health education in general practice, etc. Another 5% of the budget is spent on the evaluation of the Council's campaigns and programmes, using market research campaigns or academic researchers.

REFERENCES

Advisory Committee on Alcoholism. Report on Prevention (Kessel Committee). D.H.S.S. 1977.

CUST, G. (1977) Health Education about Alcohol in the Tyne Tees Area. International Conference of Alcohol and Alcoholism. Liverpool, 1978.

EDMUNDS, R. H. and YARROW, A. (1977) Newer fashions in illegitimacy. Brit. Med. J., 1977, **1**, 701–703.

Report of a Joint Committee of the Central and Scottish Health Services Councils on Health Education. 1964 (Cohen Committee), H.M.S.O., 1964.

HOMOEOPATHY—the continuing paradox

by J. B. L. Ainsworth, M.P.S., A.F.Hom.,

Pharmacological Adviser to The British Homoeopathic Association

Homoeopathic medicine and homoeopathic preparations have been available in the N.H.S. since the start of the Welfare State in 1948. The major European countries reimburse the patients' costs for homoeopathic treatment and medicine.

The State of India provides education for those medical practitioners who choose to pursue this approach to treatment. It is only India and Brazil however that "officially" recognise homoeopathy and support medical teaching to the subject.

Homoeopathic text books inevitably speak of the exclusion of the subject from formal medical education for a great deal of the time. In

parallel with the attitude of the medical "establishment" is the equal determination of large slices of the public internationally to ensure continuance of its existence either through encouraging doctors to take post graduate study courses or by use of the medicines in a first aid or self-care role and to a degree through the interest of unregistered practitioners in the subject.

That a problem now exists in respect of the provision of homoeopathic medicine within the Welfare State Scheme is evident from the fact that over 250 M.P.s are willing to sign a motion designed to achieve a much better status for this medical speciality which has always been the subject of controversy in medicine.

This situation seems largely to revolve round proof of its validity in "scientific" medical terms. Somehow homoeopathy, which takes as an essential element of diagnosis leading to prescription of medicines, the "feelings" of the patient, is expected to put this essential variable factor into some acceptable straitjacket.

Perhaps these brief notes of the basic idea behind homoepathy may stimulate interest in varying degrees. Further reading in depth can be obtained through the library and information services of the organisations listed below.

A person suffering from an illness characterised by a certain set of symptoms will be treated homoeopathically by the administration of a substance which in health would provoke a similar set of symptoms. This concept is implicit in the word homoeopathy itself, which is made up of two Greek words meaning "similar" and "suffering". It is also often expressed in a Latin phrase coined by its founder, "Similia similibus curentur"—"Let likes be treated by likes".

Homoeopathy was first formulated as a coherent medical doctrine by the German physician Samuel Christian Hahnemann, who was born in Meissen, a town famous for its porcelain, in 1755. Samuel Hahnemann was a man of many talents. In his youth he was an outstanding scholar who worked his way through college as a medical student by translating scientific works and giving language lessons.

He qualified as a doctor in 1779 and practised medicine for a number of years, earning a considerable reputation among his contemporaries for his medical skill. Despite his success he became increasingly discouraged by the miserable condition of medical science at the time and gradually withdrew from active practice, busying himself in translating and writing on many medical and scientific subjects.

Whilst engaged in translating into German Cullen's Materia Medica, a standard medical text book of the time, he felt dissatisfied with the author's account of the mode of action of Peruvian bark (Cinchona, from which quinine is derived) in the treatment of intermittent fever. He experimented repeatedly taking some of the drug himself to observe its effects and was intrigued to discover that its effect upon him in health closely simulated the symptoms for which it was recommended in sickness. As a result he began to suggest tentatively that the drug's efficacy in fever was due to the fact that it could cause fever-like symptoms. Hahnemann went on to experiment with many of the medicinal substances in use at the time and with a group of colleagues developed his theory of "similars" in treatment.

Putting his idea and observations to the test he found the medicines proved effective in the conditions treated, but conventional doses of them when employed in this fashion often produced an initial worsening of the

symptoms. This led to an attempt to minimise this aggravation by reducing the size of the dose and to the observation that the progressive dilution of the drug could be carried to very great lengths without impairing its beneficial action. Indeed the curative action seemed to be enhanced by dilution especially if carried out in a particular manner. At the same time harmful effects were decreased.

Hahnemann won many adherents, both doctors and laymen, to his doctrines and with their help began a systematic investigation of the action of drugs in healthy individuals, with the object of determining their effects in health and thus establishing the disease-conditions in which they would be curative. In all, nearly one hundred drugs were proved in Hahnemann's lifetime and the results published in his "Pure Materia Medica" and "Chronic Diseases" between 1811 and 1821. Many additional drugs have been proved since Hahnemann's time and the Homoeopathic Materia Medica today comprises a formidable array of medicines, of each of which one can say with justification that they are of proven value.

Although science cannot yet fully substantiate the thesis upon which the whole of homoeopathy is based, advances in other fields of medicine do seem to have brought nearer the eventual explanation of the facts noted by Hahnemann and expressed by him as a coherent medical system. Since the days of Pasteur, Koch and Almroth Wright it has been known that the administration of microbial agents, or of the poisons they produce, can stimulate the body's defences against infection. Another analogy which could be advanced is the use of minute doses of a substance to which an individual is known to be allergic to help overcome the allergy.

The aim of homoeopathic treatment is to find and administer that drug whose symptoms as recorded in the provings correspond most closely with those observed in the patient. This process of selection is often called finding the "simillimum", the most similar drug. Drug picture and disease picture should coincide if the physician is to be sure that he is selecting the correct remedy.

It is obviously helpful to classify the most effective medicines for specific conditions if practicable, "Gelsemium" for influenza, "Drosera" for whooping cough, "Rhus Tox." for rheumatism; but several others such as "Bryonia", "Eupatorium Perf.", or "Baptisia" may equally well be the choice in the various disease-pictures which are grouped under the broad classification of influenza. Similarly the correct remedy for a given case of whooping cough may have been selected from some dozen possibles. Homoeopathy is essentially an individual treatment and no malady can be managed efficiently with its aid unless the prescriber takes full account in the case-taking of the actual symptoms exhibited by that particular patient at that particular time.

In assessing the significance of symptoms, the homoeopathic physician first grades them into "generals", i.e. those involving the whole body or personality such as "I feel tired", and into "locals" (or particulars) for instance "my stomach pains me". The general symptoms carry greater weight than do the locals. Particular attention is paid to mental symptoms since these constitute accurate, sensitive pointers to the selection of the correct drug. Undue irritability, depression, odd fears, shyness, tearfulness, an hysterical tendency, over-sensitiveness to sights, sounds and smells, all are signs which will be of value.

Probably no aspect of homoeopathic treatment is more puzzling than the use of the medicine in such minute quantities, and without actual experience of their efficacy it is difficult to explain how they can have any effect at all. However, the minute dose is not the fundamental principle of homoeopathy. The basis of homoeopathy is the use of the "similar" drug and the employment of microdoses is a secondary development. From experience homoeopaths have found that the "low" potencies, i.e. those in which the dilution has not been carried to very great lengths, are relatively short-lasting and superficial in their effect. The "medium" potencies are somewhat longer-acting and appear to exert their influences on a wider and deeper range of symptoms. The high potencies are more fundamental still in their action and appear to continue their effect for a considerable period even after administration has ceased. These high potencies have particular value in the treatment of deep-seated chronic conditions, and their use should be left to the physician who knows how to exploit them to the best advantage.

Homoeopathic Preparations are obtained by using various methods of successive dilution and trituration from the following raw materials:

1. Mineral materials such as metals, salts, acids, as well as synthetic medicines.
2. Products of vegetable or animal origin.

From basic materials one prepares:

a. Suscus and mother tinctures from fresh plants, or exceptionally dried plants.

b. Mother tinctures of materials of animal origin.

c. Solutions or triturations of chemical products.

The dilutions and triturations customarily employed are obtained under prescribed conditions respectively in liquid medium (with succussion) or solid medium. They are called either decimal or centesimal depending on the successive operations being made in steps of 1/10th or 1/100th. The number of operations carried out in such manner determines the degree of dilution or trituration obtained in this way.

The property residing in the minute dose which takes advantage of the special sensitivity of the patient to this individual stimulus reduces also the problem of "side effects", adverse reaction, drug interaction, etc., to infinitesimal proportions. Although it is repeatedly stated that no effective medicine is devoid of risk the problems associated with conventional medicine in this sense seems not to be encountered in the many homoeopathic prescriptions administered over the years.

Homoeopathic organisations

The Faculty of Homoeopathy,
The Royal London Homoeopathic Hospital, Gt. Ormond Street, London, WC2N 3HR.

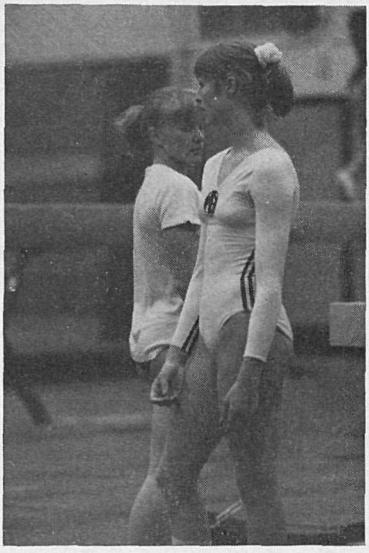
The British Homoeopathic Association,
27a Devonshire Street, London, W1M 1RJ.

The International Homoeopathic Medical League,
c/o International Vice-president, Dr. C. O. Kennedy,
Royal London Homoeopathic Hospital.

The International Homoeopathic Pharmacists Committee,
Dr. G. Peithner, Pharmacist-General Secretary,

EDMONTON 1978: PSYCHOLOGY AND THE SUPERIOR SPORTSMAN

by Maurice Yaffé



Joanna Sime (front) and Karen Kobb

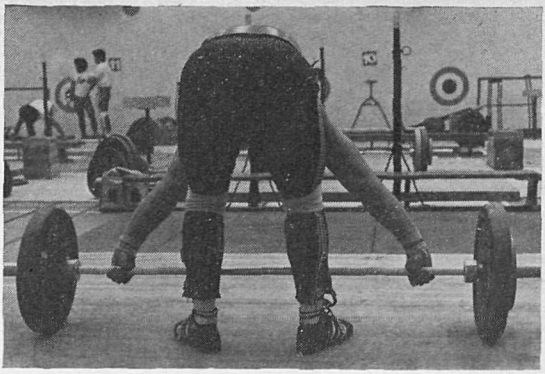
The Editor asked me to make a contribution to the *Gazette* on the place of a psychologist in an Olympic set-up, and in particular, make some comments about what a psychologist was doing at the recent Commonwealth Games held last month in Edmonton, Alberta. The reason I was asked is that I was fortunate enough last year in being appointed as Psychological Adviser to the British Olympic Medical Sub-Committee, the first appointment of its kind to be made in this country. The East Block countries, notably the U.S.S.R., East Germany and Czechoslovakia, have had psychologists attached to their national athletics teams for some considerable time; and Canada had three psychologists in Edmonton with their team (attached to the swimmers and gymnasts plus one with no specific team commitment). As you know, for the purpose of the Games, the British Isles is divided into separate countries, and so my specific attachment was to the English team.

I was there on a research project jointly funded by the Sports Council and the British Olympic Association to look at the following issues :

(1) To get to know the team managers for each sport and their coaches in order to find out what they felt a psychologist could contribute.

(2) To observe and make contact with the athletes in order to determine the demand characteristics of each sport and how these were

Gary Langford



approached by each individual—there were 250 competing in all—though at this stage my intention was not to interfere in any way with training programmes, but rather to get a feel of the competitive situation in terms of what role mental training might play in optimising performance in the future.

(3) To spend time in the England team headquarters office to make some assessment of demands made of staff, with a view to making recommendations about future headquarters organisation.

(4) To spend time in the Athletes' village in order to see how competitors' stresses and pressures presented and were dealt with; to look at ways of improving the life of the athlete in the future—with Moscow 1980 in mind, of course.

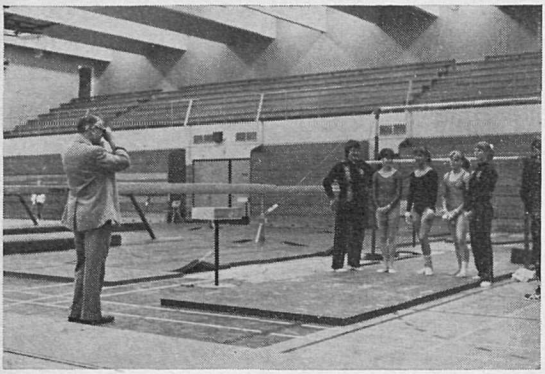
(5) To liaise with the medical staff to see to what extent problems presented could be resolved by psychological intervention, and perhaps reduce the likelihood of these occurring in the first place.

(6) To find out what psychological colleagues attached to other teams (only Canada as it turned out) were doing for their charges.

At the end of the competition, athletes and coaches were given one of my questionnaires on mental training which included questions of: whether length of stay in the Village prior to competition was optimal; whether boredom was an issue before the Games started, and up to the time of competition; whether there was ease of access to medical and administrative staff; and I requested a rating of psychological factors considered important for doing well in competition.

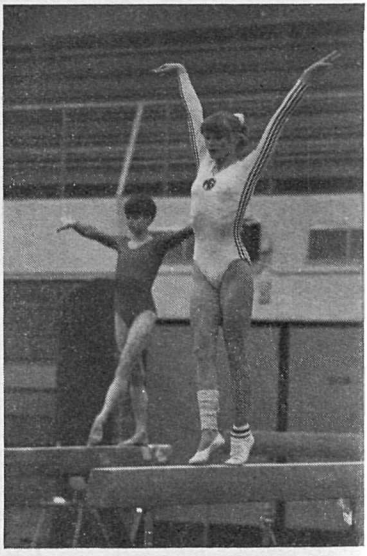
As you can appreciate, the demands of each of the ten sports represented at Edmonton, Athletics—by far the largest number, Swimming, Shooting, Cycling, Gymnastics, Bowls, Boxing, Wrestling, Badminton and Lacrosse are rather different, and so too are the competitors in terms of *age, physical size* and *temperament,* which of course, varied considerably within and across the sports. Most coaches and a lot of athletes I spoke to conceded that psychological preparation for competition was crucial, and some claimed that this wasn't handled nearly as thoroughly as the physical.

All the athletes had demonstrated high level skills in their sport in order to qualify for a place in Edmonton, and if all had realised their potential, there is no doubt that we would have had more medals, and maybe some more personal best performances.



Mr. Howell, Sports Minister and photographer

Clinical psychology has a great deal to offer sport in addition to the above. In the area of sports injuries for instance, behavioural assessment allows us to make predictions with regard to the probability of an athlete getting injured, the psychological aspect of the injury and its management, and the likely outcome in term of adaptation and further recurrence of the injury.



Joanna Sime (front) and Susan Cheeseborough

Problem athletes, i.e. those who fail to succeed in competition at the level at which they are physically capable, can be classified as those who deliberately transgress the rules; the hyper-anxious; those who resist coaching; the success phobic; the injury prone; and the depression prone. Behavioural psychology enables assessment of the problem through interviews, self-report schedules and inventories, self-monitoring procedures, analogue measures, direct observational and psycho-physiological procedures.

Stress management and other behavioural techniques such as relaxation, autogenic training, biofeedback and mental practice have proved their effectiveness in preparing problem and other athletes and those who have been injured. As far as the *ethics* of intervention are concerned, the psychologists' first priority is naturally toward the athlete but the athlete must be the one who seeks help; exploitation and deception by the helper must be avoided while the helper must be aware of his own limitations and refer on where indicated; and the psychologist must intervene in the athlete's everyday life and to the extent that it is necessary for change.

It is now clear that the behavioural psychologist can play an integral part of the inter-disciplinary sports team comprising the physician, coach, and physiotherapist. We undoubtedly have some of the finest athletes in the world and I hope you share my optimism for a realisation of lots of potential in Moscow 1980, Brisbane 1982 (the venue for the next Commonwealth Games), and wherever after.

QUODLIBET SOCIETY

HeldlingerHauptstrasse 86, A1121 Vienna, Austria.

The evenings are closing in, and we are back to having R's in the month again. There is some consolation to be had, nevertheless, in that Quodlibet's winter programme is now nearing completion. With most politicians preparing for a non-existent election this autumn, we have had to forego our usual political bias, and will be inviting psychiatrists, journalists, academics and philosophers instead.

On Tuesday, October 24th at 5.30 p.m. in the Anatomy Theatre, there will be a talk by **R. D. Laing**. Well known as author of the *Divided Self*, *Sanity, Madness and the Family*, *The Politics of the Family*, and *Knots*, among many other books, Laing has established a world-wide reputation. His ideas on psychiatry have created controversies the like of which have not been seen since the days of Freud and Jung. Indeed psychiatrists today may be observed to inquire of each other in a matrimonial way: "Are you with Laing?" His attention is by no means confined to psychiatry, indeed he sees psychiatry as no more than a reflection of society and its internal politics. Possibly too much so. The audience will also be able to hear his unusual views on medical education, which have probably been listened to too little. In the end it is not necessary to love or to hate R. D. Laing, but it is impossible for serious minded people in medicine to be unaware of what he is saying. Tea and biscuits will be served as usual at the meeting, and plenty of time will be reserved for questions and discussion. Anyone wishing to meet Dr. Laing at drinks afterwards should drop a note in the Quodlibet pigeon-hole in the East Wing (Boland House).

Other meetings this term still require confirmation. They include a talk by a renowned Oxford Philosopher on Wittgenstein, whose dated plaque stands in the pharmacy. There will be a debate on censorship, hopefully with the editor of the sex-maniac's diary and other proposed meetings are a professor of war on urban terrorism, and **Harold Evans** of the *Sunday Times*, who may be coming in December.

Full details of our programme will be available at the Fresher's Fair as will our 20th anniversary badges, donated by an anonymous benefactor. We shall be having our elections in a month's time and our anniversary party for those, who have been involved in Quodlibet over the years, later on next term.

In all 1978 and 1979 look like being good years for Quodlibet, but we need new blood to organise the society, and hope to reach new audiences in the future. It is with this in mind that we extend a warm welcome to all those who have just started at Guy's.

Michael Dixon.

THEATRE

Marcel Marceau at Sadler's Wells: Master of Mime

It was pleasing to see quite a fair contingent of Guy's scholars taking time from their book-bashing to enjoy a performance by Marcel Marceau, now recognised as the Master of Mime. I'm only sorry his show ended in August so I can't tempt you to go, however, should the opportunity ever arise do not miss a chance to see him. He has recently been popularised with a small part in the film *Silent Movie*.

At Sadler's Wells Marcel Marceau put on a mixed show of the comic and serious, the first half consisting of a few of his more famous sketches. At all times concentration is very important; two seconds daydreaming and the thread of the scene is lost. This concentration for two hours requires considerable effort, much harder than gawking at *Grease* or *Saturday Night Fever*, but is amply rewarded by the hushed atmosphere of the occasion.

The second half was a presentation of the famous adventures of Bip the Clown. Bip brought the true flavour of the theatre to Marceau's performance with the clown's humility and pathos, and it also contained the best humorous movements of the evening. Bip is said to be modelled on Charlie Chaplin. There was Bip as lion tamer trying to coax his animals to jump through hoops, Bip as Don Juan (who filed his fingernails with his sword between encounters) and Bip as David who invited Bip as Goliath to share the applause after their one man battle.

Mime is a tremendous mixture of ballet and art requiring dance skills and also a delicate observation of life combined with a subtle sense of humour. Marcel Marceau can extract the maximum from every portrayal with superb use of all these skills, combining them and presenting them with great personality and showmanship. It is said that when he presses his fingers against some imaginary object, those sitting in the front row can see his finger pulps go white. He is the true master of mime.

J. J. E.

National Mutual Life can arrange 100% mortgages for Doctors and Senior Staff.

National Mutual Life has negotiated special arrangements with over 40 leading building societies to establish the unique 100% Joint House Purchase Scheme.

Under this joint scheme, in which National Mutual Life is a second mortgagee, a combined loan of up to 100% of the required amount will be considered — based on the purchase price, or surveyor's valuation if that is lower.

National Mutual Life was founded in 1830, and now has assets exceeding £100million, with more than 50,000 policyholders. We have established particular expertise in the area of 100% mortgage facilities, with over 15 years as leader in the field.

For further information on the 100% Joint House Purchase Scheme, please write to the address below.

National Mutual Life

National Mutual Life Assurance Society (Founded 1830)
5 Bow Churchyard (off Cheapside) London EC4M 9DH
(Registered Office) Telephone: 01-236 1566

Registered in England No. 48949C. Member of the Life Offices' Association.

FILMS AND T.V.

H., as every kindergarten child knows, stands for "hispidity", which means the state of being hispid or "rough with bristles". It also stands for a word that should be in the repertoire of any serious party-goer, and that is "heterotomous", which means "the having of a different cleavage". **Housecalls** (Fulham Road Cinema and many others) and **Holocaust** (BBC I this summer and bound to be repeated in the autumn) both begin with H., and belong rather more to the hispid, than to the heterotomous side of life.

Housecalls, which is about an American surgeon, would amuse most actual and would-be surgeons, as well as the rest of us. Widowed, yet not quite past it, the surgeon in question (Walter Mathieu) finds to his surprise that all the nice girls love a surgeon. And he spends some time tasting the delights of the nice girls, until the nasty, stubborn yet vulnerable Glenda Jackson comes and scoops him up. This provides a few laughs:—A: "You have very infectious laughs"; B: "That's the only thing about me that is infectious"; or A: "You know most of our infant wards have closed circuit television"; B: "What do they watch?" It also provides a conflict in our surgeon, who really prefers uncomplicated floozy bashing, but feels that deep felt monogamy is better.

Light relief comes by way of the Chief, and very lethal surgeon of the hospital, Ames Willoughby. Having heard that "when Willoughby doesn't know what to do, he takes out the gall bladder", it is of some concern, when the hapless Willoughby is seen walking around in surgical kit. No one need worry, however, he has only been washing his car in it. Indeed he protests his own sanity rather unconvincingly, "People may say that Ames Willoughby is going senile, but I can get it up three times a week."

The film touches "superficially" on the question of the ethics of private medicine, and more especially private surgery, in the U.S. of A. "Unpretentiously" might be a fairer word, however, for the film succeeds in providing an extremely pleasant evening without being earth shattering.

Earth shattering, nevertheless, is a fair expression to apply to the ritual murder of over six million Jews, and it is difficult to see how any art form, especially television, can do justice to that topic. Yet those, who have said that only a documentary can depict the atrocities and the inner truths, are not of the 1970's. For, sad though it is, most of us demand that the media should entertain us as well as inform us. Cynical and patronising though the remark may sound, it is undeniable, when it comes to explaining why our most popular Daily and Sunday newspapers have nudes splattered all over them (just like the *Gazette*) and why most of television is as it is.

Within the context of how we communicate in the 1970's, therefore, **Holocaust** was a clever and true to life account of what happened during those dark days. Helped with some distinguished acting by David Warner and others, it also provided a timely reminder to those, who had forgotten about, or never witnessed those events.

It does not describe the real horrors—nobody could really be expected to do so, and it is doubtful whether that would be a good idea anyway. It is historically inaccurate, though accurate enough, and its style of Hollywood romance does push it towards the domain of "soap-opera". Worst of all, perhaps, it completely fails to explain, why a race, which is genetically so similar to our own, ever committed those atrocities and to explain why the Jews were so unpopular in many other quarters outside Germany at the time.

It may well be true that the horrors of **Holocaust** tend to blunt our emotions, and for those who watch it, the Rhodesian air crash, which occurred in the same week, appeared trivial by comparison. They should, however, put us on our guard when we start dismissing suspected atrocities in Uganda or Eritrea for instance, in rather the same way as we dismissed the atrocities committed against the Jews during the war.

A final note, while on television, is to recommend to you the season of **Francois-Truffaut's** films late on Saturdays on B.B.C. 2. They are sub-titled, but that is the penalty for watching films by France's greatest film director. Then perhaps you've got better things to do on Saturday nights . . .

Michael Dixon.

RADIOGRAPHY

Radiography in Crime

Recently Prof. Keith Simpson gave a talk at Guy's to the London and Home Counties Branch of the College of Radiographers on the importance of radiography in crime detection. The lecture was given to a packed audience of radiographers and students after refreshments in the nurses' home.

Prof. Simpson emphasised the need for speed and expertise in forensic radiology as most investigations cannot be repeated. As always it is the observation and experience of the radiographer involved that counts. His or her logical approach must outweigh the handicaps of equipment.

From the beginning of the lecture Prof. Simpson's humorous delivery of his morbid subject had the whole audence spellbound. He took them through various cases involving negligence and civil law suits onto many famous murder cases, and then to the more obtuse uses of radiography in crime—such as bombings, smuggling of contraband, baby battering and identification of remains. It seemed that the more lurid and scandalous the crime, the more enrapt the audience!

After a question and answer session from amateur sleuth radiographers, the audience gave hearty applause for a very interesting and most enjoyable lecture. Thank you once again Prof. Simpson!

Jill Guest.

NOTICE

GORDON MUSEUM

From 2nd–31st October inclusive the Gordon Museum will remain open until 8.30 p.m. on Mondays, Tuesdays and Thursdays, primarily for students taking the MB Pathology examination in November. All the normal facilities of the Museum will be available.

J. D. Maynard,
Curator.

PHYSIOTHERAPY

Halsbury latterly dragged the ends apart letting in great gusts of fresh air—admittedly leaving small areas of non-expansion which have subsequently been re-inflated—so that there is now room to slip a toe between the several rings of a different metaphor *en route* to the top. But, for the future, Nichols is right! We do need a hierarchy, we do need graduate therapists, researchers, specialists et al.—and we do need, in the country at large, a sizeable body of aides, helpers, assistants, what you will. Provided that—and this is a major proviso—the therapists do not become mere assessors, report-writers, working-party members, advisors, consultative and/or decorative appendages, while the real therapy is carried out by the army of locally-recruited (etc.) workers.

Far be it from me to knock attempts to raise the career ceiling, but even further should it be from me to dissuade physiotherapists from banging chests and holding sputum pots, from re-abling hemiplegics, from nudging recalcitrant joints into greater mobility—from using their brains, in short, as well as their hands.

I have no objection to becoming Regional Physiotherapist if invited-er-designated. Except that the job-description will almost certainly expect that the duties will involve about half-an-hour a day above present commitments and will be "remunerated" by some such figure as £71.49 per annum! If Dr. Nichols can persuade the Department that it is possible to develop a therapeutic organisation that is at once erudite, questing, skilled, practical and, unconventionally well-paid then yet more power to his elbow!

The time has come, Dr. Philip Nichols is quoted as saying, "for the remedial professions to establish an appropriate hierarchy". This must include entry into the professions at different levels, with therapists, specialists, graduates, teachers, research workers—all with appopriate gradings and remunerative rewards—supported by a wide base of registered assistants, locally recruited and trained in post.

Not having been at Strathclyde, I am not able to say whether there was a sharp in-take of collective audience breath at this pronouncement, or whether visions of Salmon-like therapists swam through their mind. Not the least of the disadvantages that the construction of the high-rise nursing megalith brought in its wake is the determination that nothing like it should ever happen again among any of the other health-caring groupings. It obscures the regrettable fact that most of their pyramids are so truncated that one has hardly set foot upon the base before striking one's head upon the ceiling. That this had been tolerated for so long despite the determined and frequently outspoken nature of many of their members can only be attributed to an historical adherence to an ethos whereby one accepted one's position in the world at large and sought to change it only at risk of unseemliness.

Readers may remember the periodic opening and closing of the wages concertina in the fifties and sixties with differentials widening and narrowing against a continuo of sound economic rationalisation of black equalling white.

Ronald Cooper.

NURSING

In a recent article in the journal of the Royal Society of Medicine, the problems which are being faced by the nursing profession were examined by a doctor. Having examined them he continued by suggesting some solutions.

Much of the article was relevant and practical, but left one to ponder about the necessity as well as the authority of a member of the medical profession to undertake such a task. How, one wonders, would a similar exercise be received by the doctors?

However, since the article has been published, some of the comments and conclusions are worth correction.

A number of the less accurate statements were contained in the section devoted to the teaching of nurses; and in one, sadness was expressed at the fact that doctors are now asked to participate in lecturing to students rather less than previously. The assumption is made that the reason for this is mainly financial. There are however other reasons.

How many doctors realise that nurse tutors—who in the opinion of the author should not exist—spend a great deal of their time attempting to persuade recalcitrant medical colleagues to talk to the students? Some of these gentlemen do not reply to letters, forget appointments and make double bookings in their diaries. Sometimes, having spent a long period arranging a lecture, the tutor finds that the exposition is delivered inappropriate to that which was required. Most tutors feel that their students should have lectures from medical staff, just as they feel that medical students should have nursing lectures.

Another comment made by the author, is that student nurses should evaluate their teachers and teaching as do medical students. This practice has been common in schools of nursing for many years, and is often the cause of doctors not bieng asked to give lectures! Furthermore, as with medical teachers, few nurses resent it and few resign!

It is surely a little unrealistic for me to suggest that nurse tutors should not exist. Maybe a more positive approach, i.e. some suggestions as to how the two disciplines could work more harmoniously together would be more beneficial.

It seems a little presumptuous for a doctor to pontificate on the teaching of nurses, in fact it could be considered as arrogance. One cannot help feeling that the doctors still resent the fact that nurses are developing into a profession in their own right, and are not now prepared to act as handmaidens who have had no education and have no original thoughts of their own.

Pam Jeffries.

BOOK REVIEWS

Textbook of Surgery. The Biological Basis of Modern Surgical Practice by D. C. Sabiston. Pp. 2465 + cxiii. 11th Edition. Price £23.50. Published by Saunders 1977.

Textbooks in general are getting heavier all the time and this one is no exception. As David Sabiston points out in his preface, the decision has been taken to provide a book which is both a definitive textbook and a source of reference for all grades of surgeons. In this respect the selected references at the end of each chapter, each with a concise summary, will be extremely useful and many of these are as up to date as possible in a work of this kind. Over 200 authors are involved including Sir Alan Parks and James Thomson from St. Mark's, who have written the section on the rectum and anal canal, and several new chapters have been added to the previous edition including acute care, intestinal bypass and breast reconstruction procedures. As in previous editions emphasis has been placed on the basic sciences and how understanding of the pathogenesis of disorders can lead to better management pre-, per- and post-operatively.

Although there are reasonably comprehensive descriptions of many surgical operations, this book is not intended as a technical guide to surgeons, nor should it be. Rather the emphasis is on pre-operative assessment as to which, if any, operation is indicated, and possible post-operative complications, with evidence to provide a rationale for the chosen plan of action.

Textbooks of this size inevitably raise questions as to their value. It is clearly not suitable for the apprentice undergraduate trying to get to grips with the basic concepts of surgery, and cannot be conveniently carried around. Post-graduates on the other hand will, I believe, find this a useful and well written series of up-to-date reviews on all aspects of surgery from which references can be followed if necessary. At £23.50 it is cheap by modern standards, and will clearly find a place in all surgical and medical centre libraries.

MARTIN JOURDAN.

"Psychology and Medicine" by S. J. Rachman and C. Phillips. Pp. 205. Price 90p. Published by Pelican, 1978.

The prime aim and virtue of this little book is that it provides a fairly readable introduction to some of the contributions that psychology can make to clinical medicine. There is still a widespread tendency to think of psychology simply as the pre-clinical preparation for psychiatry but this book succeeds in showing not only its treatment possibilities for other types of clinical problems but also the light which it can throw on some central issues in medicine. Thus it concerns itself with the psychological approach to the understanding and treatment of such problems as headaches, sleep disorders, over-eating and smoking. It also has chapters on the placebo-effect, pain, biofeedback, doctor-patient communication and the psychological effects of hospitalisation.

Although not stated specifically, it would appear that the objectives of the book are to indicate the range of opportunities open to the clinical psychologist and to herald the value of psychological approaches to those in mainstream medicine. Unfortunately it is not a textbook for a pre-clinical psychology course since it contains very little basic psychology but it would make a reasonable companion to a good basic textbook, if one existed.

This book was originally rather shoddily published in hardback three years ago but somehow looks better as a Penguin. Even so there are a number of faults, the most serious being that the book is often rather uncritical in its presentation of information. A glaring example is the section on the gate theory of pain, which makes no attempt to indicate the many inadequacies of this theory which have been demonstrated in recent years.

In its present state the book looks to be rather hastily written and at times poorly organised. This is a shame because it could have been a good book with a little more thought and preparation. As it stands it is moderate and is therefore moderately recommended.

JOHN WEINMAN.

"The Pathology of the Placenta," by Harold Fox. Pp. 491. Price £17.50. Published by Saunders, 1978.

This book is a detailed review of placental pathology, in which the author indicates quite clearly his own views in relation to the general literature of the subject. This presentation is enhanced by the author's considerable personal knowledge and experience of his subject. The author's characteristic dry humour provides a pleasant introduction to each subject in turn and encourages the reader to continue along each particular avenue of knowledge.

There has been considerable confusion and ignorance about placental pathology in the past, but with Professor Fox's book to hand, there is now far less excuse. Hopefully, in future, the obstetrician who sends placenta tissue to the pathologist for histological examination will obtain more meaningful information than in the past.

The chapter on trophoblastic tumours by Dr. C. Elston is of the same high standard and the illustrations are good throughout the book. I would strongly recommend this monograph to any pathologist likely to be involved in diagnostic histopathology of placental tissue. It is an excellent reference book and is sufficiently well written to be read from cover to cover.

D. R. TURNER.

"Synopsis of Radiologic Anatomy with C.T.", by Isadore Meschan. Pp. 762. Published by Saunders.

For those beginning a career in radiodiagnosis the first six months have, in the past, been dominated by the acquisition of a knowledge of basic physics. With the introduction of the Part 1 F.R.C.R. examination, anatomy and technique have been introduced as topics for formal study. Both of these topics are covered extensively in "An Atlas of Anatomy Basic to Radiology" from which this synopsis is derived. A synopsis though it may be it is still large enough to make one hesitate to transport it in a briefcase and it contains a considerable amount of information.

On first turning the pages the impression given is that here is the answer to the Part 1 examination. Everything appears to be covered from how to X-ray an extremity to some of the finer points of neuro anatomy. The illustrations are largely selected from journals and text books and are therefore not tailor made for the text and there is a variety of styles and lay-outs. However the information is usually there but it may have to be searched for.

There is a chapter dedicated to whole body computed tomography with axial sections taken at each vertebral level from the cervical region to the sacrum. Unfortunately the density differences from one soft tissue to another often are too subtle to be apparent on the reproductions. When one knows what the scanner can produce the feeling one gains from this chapter is of disappointment.

This feeling of disappointment occurs in other chapters and I take an example from the chest section. There is the usual anatomist's obsession with the bronchogram, eight pages in all. Yet nothing about conventional tomography of the hilar structures or of the bronchial tree. Yet tomograms are performed daily in most departments, bronchograms rarely.

One feels that if each chapter had been written by a specialist in that subject there would have been quite different stress on certain aspects of anatomy which would have provided a better reference volume for more senior radiologists be they still in training or as consultants.

However these criticisms aside I have yet to see another textbook of radiological anatomy in a single volume which is as comprehensive as this. Approached selectively there is material which will interest medical students as well as radiologists and complement the textbooks already in common use.

A. J. S. SAUNDERS.

"Microbiology in Health and Disease," by Fuerst. Pp. 684. Price £10.00. Published by Saunders 1978.

On first seeing this book I groaned ("Not another Microbiology text book!"), but I then noticed that it came out first in 1919, and this is the 14th Edition. Clearly it commands some respect from the reviewer. It is a clearly written and up-to-date account of microbiology; the many tables and diagrams are models of clarity. There are 41 chapters, at the end of which are supplementary reading lists with the references dating up to 1977. It is a pleasure to see good sections on public health matters such as sewage disposal and sterilisation. On the whole the microbiology is reliable, although there are omissions, such as the failure to mention the rotaviruses in the chapter on Enteric Viral Infections.

It is well produced, and with nearly 800 pages, very reasonably priced, but who is it for? Apparently it relates to a course that is given, presumably, in Professor Fuerst's department at the Texas Women's University, Denton, Texas. Some of it is directed at nurses and allied health personel. But there seems no particular readership in this country, although the book would be useful as an up-to-date reference volume in Medical Microbiology. In a 15 page appendix on teaching films and filmstrips, that are available, all the addresses are in the U.S.A.

In summary, a fine text for those that take a course centred round it, and for the rest, another reliable reference book.

C. A. MIMS.

"1,001 Multiple Choice Questions and Answers in Surgery," by A. J. Harding Rains. Pp. 221. Price £4.00. Published by H. K. Lewis, 1978.

As an impartial test of factual knowledge the multiple choice examination has, as the author remarks, come to stay. This little book provides plenty of practice in the art as applied to surgery, and should provide good reading on the train north for those candidates sitting final fellowship beyond Hadrian's wall. However undergraduates and London fellowship candidates should not be put off by the dryness of the subject matter, for this is alleviated by an entertaining historical section at the back. For example Guy's men will be interested to learn that Sir Percival Pott, having fractured his leg on London Bridge, did *not* "hire a hearse to take him to Guy's" as one of the incorrect answers cheekily suggests.

The main objection to a book of this kind is the dull dogmatism of the multiple choice test itself. As a system for assessing factual knowledge the multiple choice test may be scrupulously fair, though I suspect that it fails to detect the brilliant candidate, and it does not set out to detect an original thinker; but as a method of teaching it is the anathema of education with its tendency to dull the mind into a state of conditioned response to a set question. An additional danger is the deliberate confusion created in the mind by the incorrect answers.

Your reviewer therefore recommends this book as a pre-examination exercise only. It should have no permanent place on the bookshelf.

T. K. DAY.

"The Acute Abdomen for the Man on the Spot," by J. C. Angell. Pp. 116. Price £1.95. Published by Pitman Medical 1978.

It is a pleasure to review this delightful book which I first looked at about five years ago and which came vividly back to me on re-reading. An anecdotal account is presented of the author's vast experience through the many avenues of emergency surgery. Perhaps the book ought to be called "humble pie" because of the way in which the author, through the retrospectoscope, reviews his mistakes and misgivings about difficult emergency problems and because of his attitude that enables him to achieve such a high degree of diagnostic ability.

He examines many of the "fundamentals" of emergency surgery—exonerating some, such as subtle signs of intraperitoneal bleeding, and rejecting others such as Rovsing's sign and the use of sterile water injections. Many of the valuable tips on diagnosis and management do not, as far as the reviewer is aware, appear elsewhere in print.

Obviously a book of this size has its limitations—resuscitation is hardly discussed, peritoneal lavage is omitted and no effort is made to present facts in a statistical manner.

Nevertheless, it proves an invaluable, amusing and instructive guide, a must for those students and doctors both on the fringe and in the throes of emergency surgery.

W. J. OWEN.

"Emergency Medical Care," by William M. Portney. Pp. 197. Price £13.50. Published by Lexington Books.

This book consists of edited papers presented at the International Conference on Remote Emergency Medical Services which was held at Texas Technical University at meetings sponsored by the N.A.S.A. Johnson Space Center and the Department of Electrical Engineering and Medical School of Texas Technical University.

As this daunting background suggests much of the book deals with communication, equipment, transportation and planning for emergency medical care in the U.S.A. where in many districts selected ambulance crews (often fire brigade staff) are trained to carry out sophisticated medical care at the scene of the incident or accident, backed by qualified medical advice given by radio or television. These crews have become known as the para-medics and starred on a television series.

A strength of the scheme has been the rapport which has been fostered between the doctors and crew members just like the comradeship between the good battalion medical officer and the first aid men or stretcher bearers in war.

The papers contain much interesting information about equipment and methods of its use. The bureaucratic problems are tackled with zest. Transport of the sick is covered by consideration of ambulances and helicopters. Helicopters usually allow a quicker, smoother journey for the patient but they are expensive and not always available. There is no report of technological advance in splinting, "patient packaging" or ambulance design with a view to minimising the harmful effects caused by movement especially jolting, on the seriously injured or sick person.

This book contains a wealth of information about technical support for remote emergency medical care but it lacks critical assessment of the effect upon the patient of the dedicated effort, knowledge and use of material resources. Some papers give tantalising signs that critical analysis of results will be forthcoming in the future and that should be very interesting.

MAJ. GEN. ROGERS.

"Medical Hubris: a reply to Ivan Illich," by David F. Horrobin. Pp. 109. Price £3.00. Published by Churchill Livingstone, 1978.

This book is an attempt to answer some of the charges levelled at the medical profession in *Medical Nemesis*.

The approach the author adopts is to evaluate each of the chapters in *Medical Nemesis* with one of his own. This was an unfortunate choice since the chapters in Illich's polemic were of very variable quality; the result is that the author tends to deal insufficiently with the crucial arguments that Illich has advanced. These are threefold: modern medicine promotes clinical, social and structural iatrogenesis.

Clinical iatrogenesis refers to that "doctor induced disease" which can be a side-effect of treatment. Illich offers little new here as it can fairly be claimed that the medical profession has been fully aware of many of the inevitable and not-so-inevitable sequelae of therapy.

In social and structural iatrogenesis Illich identifies the tendency of modern medicine to remove our ability to cope with our own problems and as a consequence make us even more dependent on medical services. This is the nub of Illich's argument, not by any means a new argument, but a useful piece of right-wing radicalism when social welfare arguments seem to be making all the running.

Horrobin however fails to tease out the full implications of this critique. He summarily dismisses Illich's contention that medicine creates medical consumers or addicts like (but less successfully) soap companies create the need to have blue speckles in washing powder. Horrobin claims that it is the consumer who is to blame for demanding the service in the first place; but this is a very simplistic conclusion which offers no analysis of the complicated relationship between consumer and producer in modern society.

Secondly whilst he seems aware of the model of man—autonomous, independent, free-willed—that Illich espouses Horrobin seems to have missed the sleight of hand by which Illich then relates this to health and medicine: healthy man is autonomous, seeing a doctor is becoming to some degree dependent, therefore doctors create ill-health. Again discussion of some of the political implications of these claims is missing.

The problem then with this book is the author's failure to confront the *values* that Illich puts forward. Instead Horrobin offers "science" and "scientific medicine" as yardsticks of truthful and humane medicine. This is simply nonsense: does a random control study of two designs of gas chamber make the successful one more humane? Moreover for all this worship of science Horrobin rides roughshod over the evidence when it suits his purpose. Did you know that the most dramatic increase in numbers of administrators has been in countries with state controlled health systems? And did you know that the best administrators are those busy and competent people who hate administration?

Illich, I am afraid wins by default.

DAVID ARMSTRONG.

"Vascular Surgery," by Rutherford et al. Pp. 1,401. Price £40.00. Published by Saunders, 1977.

This splendidly produced volume written by many authors covers all aspects of vascular surgery in a very comprehensive manner. There is something for everyone since it includes detailed analysis of blood flow in vessels, and its relationship to the pathophysiology of vascular disease as well as useful

descriptions of operations and hints on technique. It is a good up-to-date review book making use of many recent articles, as well as a complete reference volume for those actively involved in vascular surgery. As far as I can see there is no aspect of either arterial or venous disease which is not touched upon although, understandably, contentious points such as the relative merits of the different shunting procedures for portal hypertension, are not discussed beyond the point of usefulness. Points of view are included, as in Chapter 140 on a new approach to the management of massive pulmonary embolism, in which emphasis is placed on early closed chest massage and circulatory support, as well as the alternative methods of management where appropriate. Cerebro-vascular disease is discussed along with a detailed analysis of the indications for and technique of carotid arterial surgery. Although ultrasound as a diagnostic method is discussed in the book, its value in carotid arterial lesions is not mentioned, and this must represent one of the few up-to-date omissions in this volume.

This book must take its place in any medical library and surgical department where vascular surgery is undertaken, although clearly at £40.00 it is not likely to be bought by individuals on a large scale.

M. H. JOURDAN.

"A Text-atlas of Cerebral Computed Tomography," by L. A. Weisberg, C. Nice and M. Katz. Pp. 337. Price £15.75. Published by Saunders, 1978.

This is a good medium-sized book with about 340 pages written by a neurologist, a radiologist and a mathematician. It is based on their experience of 5,500 scans performed at the Tulane Medical Center, New Orleans, Louisiana mostly with the EMI Mark I Scanner. The brief introduction on the clinical impact of CT scanning could have been usefully expanded by a discussion of its cost-effectiveness. The chapter on the principles and technique of CT scanning needs to be read by the non-mathematician in the clear light of morning rather than the tired evening haze. Illustrations would have helped clarify this section. The chapter on anatomy would have been better for some comparative post-mortem slices. Unfortunately, many of the scans are technically imperfect being partly spoilt particularly by movement artefact. These criticisms should not detract from the value of the systematic treatment of neurological problems which forms the bulk of the book. The chapter on "neurological deficit of rapid onset" makes fascinating reading as we learn how unreliable are the traditional criteria for distinguishing cerebral infarction from haemorrhage. Each well-referenced chapter is an illustration of how the CT scanner can teach us more about neurology. This book at £15.75 deserves a place on every medical library and on the bookshelf of every neurologist. Every physician who looks after patients with stroke will want to read about the value of the CT scanner as a diagnostic tool. Whether better diagnosis will lead to better treatment is a problem for a future edition, which this book certainly deserves.

R. A. C. HUGHES.

CORRESPONDENCE

Computerised Tomography

Sir,

May I congratulate you on your excellent Scanner Issue and comment on same of the statements made Passim? While it is true that St. Thomas' have just installed a whole body scanner provided by private funds for research, you Sir must be the only person aware of the delivery of a scanner to King's College Hospital.

The head scanner at the Maudsley Hospital is a Guy's scanner serving our patients at our Neurosurgical Unit. Those of us who work there and at Guy's suffered many "missed-beats" between April 1972, when Hounsfield's invention was first described, and April 1977 when we performed our first scan. Our applications to the D.H.S.S. for a scanner were turned down on several occasions and we determined to seek financial help from charitable sources. We are particularly grateful to the Special Trustees of Guy's Hospital who made the first contribution—what Mr. Burfoot described as "priming the pump". With various other donations and a grant of £100,000 from the R.H.A. we had nearly reached our target and purchase of the new fast EMI scanner, the CT 1010, was made possible by the Board of Governors of the Maudsley Hospital who also provided the accommodation.

You refer Sir to problems but do not specify them. Obviously if computerised brain tomography (C.T.) is provided, it must be available primarily to neurosurgical patients. There are in Guy's a few patients who are so ill that they cannot be transferred for examination even if accompanied by a life-support team. This number is small in relation to the neurosurgical patients who need an urgent scan in the pre- or post-operative period. I believe we have a very good system for selection and referral of Guy's patients for C.T. and I am very grateful to my neurosurgical and neurological colleagues who have made this possible by devoting their valuable time to seeing many extra patients. In considering suitability of patients for scanning it is important to understand the requirements for a successful scan. The patient's head must be motionless for four or five periods of 60 or 80 seconds (not 4½ minutes) while the X-ray tube (one only) and 16 detectors scan and index around the patient's head. Obviously there are patients who are unable to fulfil this requirement or who may be disturbed by the intravenous injection of a large volume of contrast medium. Such patients may require general anaesthesia and their examination should be discussed with a consultant neuroradiologist. For the patient able to co-operate, C.T. causes no more stress than many other X-ray examinations. His head rests comfortably immobilised on a support—not in the water box of the original head scanner. Your readers will be welcome to visit the C.T. department to witness an examination so that they can prepare their patients for what we believe to be a simple, safe, quick and immensely valuable examination. The cost of a scan is rather less than the daily maintenance cost of a patient in Guy's and the cost-effectiveness of the scanner should be exploited by referring patients whenever possible as out-patients for examination.

With regard to C.T. at Guy's may I reassure you Sir that all the Guy's Radiologists have followed with interest and enthusiasm the development of whole body (general purpose) C.T. scanning and are convinced that this technique is essential in the management of certain patients with malignant disease as well as many other conditions. We are faced with one particular problem over and above that of finding the money to buy and operate the scanner. This is the choice of equipment. The development of C.T. since 1972 has been spectacular and once the money becomes available, and I am sure it will be found, the scanner will have to be ordered in the knowledge that by the time it is delivered a better scanner may be on the market. I will welcome the installation of a general purpose scanner in Guy's, not only to meet the needs of the small number of patients who cannot be transferred to the Neurosurgical Unit, but also because of the years of frustration I experienced before C.T. Brain scanning became available to Guy's patients.

R. D. HOARE.

The Neurosurgical Unit,
The Maudsley Hospital,
London, SE5 8A.

Where have all the doctors gone —a student replies

Sir,

The Passim in the July edition of the *Gazette* has spotlighted the vexing problem confronting final year students taking M.B., B.S. examinations. It is whether or not to take the conjoint exam as a safeguard against failing M.B.? Although your article was necessarily brief, the author was obviously astute enough not merely to blame the results on the new clinical course (although this naturally had *some* effect in unsettling staff and students) but to explore other factors involved, e.g. exam orientation.

As a student in the above situation my first inclination would be to dismiss taking conjoint as a needless exercise. However, that would be in an ideal situation, and one which unfortunately we are not all in. It is entirely realistic for any student to accept that failure can befall even the best prepared, and often as a result of either bad luck or poor examination technique (rarely lack of knowledge) on the other hand, the necessity of "expected disaster" Guy's students are apparently not confident enough or indeed adequately prepared to face the M.B. examinations. Proper orientation towards exam technique should be emphasised strongly in final year firms' and hence is curable as a cause for failure. Obviously, taking conjoint gives the student an advantage in this respect if the idiom "practice makes perfect" holds true.

But why the discrepancy between the failure rates in Surgery and Medicine? The S.M.E.C. questionnaire quoted in the article probably holds the key to this question—surgical *experience* (as opposed to lack of teaching) is patently lacking at Guy's.

The solution probably lies between creating a new surgical firm in a peri-

pheral hospital attached to Guy's (which has inherent financial problems) or, re-allocating the time spent studying surgery, on the regional appointment or elective periods—i.e. enforcing a period of surgical training in addition to pre-existing surgical firms at Guy's. The latter idea would seem most appropriate. If the point about experience remains valid, then taking conjoint in December and April, entailing further "bookworm" activity at a time when the summation of a student's clinical experience on the last two general firms is becoming of paramount importance, will entail these clinical activities. Books are not a substitute for seeing patients, and dealing with these patients is learnt on the wards, not from a book over a cup of black coffee!

The final decision is difficult to arrive at and is strictly a personal choice. The major considerations are probably (a) forfeiting the first house-job by failing M.B. and remaining a student (without a grant) for at least another three months; (b) the extra work created by the conjoint exams, and (c) the price for entry into the conjoint exams (approx. £120). Finally, personal confidence plays a major role, and for those lacking confidence taking conjoint is probably the best alternative. However, even for the confident student, the nagging doubt remains about being one of the unlucky few who do fail M.B. Hopefully, future final year students at Guy's will not have to face this decision when some of the aforementioned problems in the course are ironed out.

Yours faithfully,

W. SCOTT-SMITH.

c/o Boland House,
Guy's Hospital, SE1 9RT.

Where have all the doctors gone —the Sub-Dean replies

Sir,

May I comment on your recent editorial concerning the results of the recent M.B. examination.

You rightly bring out the most important point that the position this year is really no different from previous years and I think it is very important for this to be borne in mind. The main reason for the sudden upsurge of worry about the results stems from the fact that very few students had taken the Conjoint examination. In previous years the majority of students had already taken the Conjoint examination before starting final M.B. and this ensured that there were usually no more than five to ten students who had failed to qualify upon completion of their course.

The reasons for our historic performance in the London M.B. examination are somewhat complex. They stem in part from our reliance on the Conjoint examination acting as a fail safe mechanism which has demoted the importance of M.B. and this might in turn explain our relative under-representation of examiners in some specialties. This has meant that the examination has become increasingly unrelated to our curriculum and many schools have recognised this problem by switching to a school-based examination similar to that we have for the B.M.S. course. By doing this, the examination can be related to the curriculum and this is something we must clearly consider in the future.

One of the major determinants of our Final M.B. success rate is our pass rate in the B.M.S. examination. There is a significant association between difficulty in passing B.M.S. and Final M.B. examinations and if we have to fail a higher proportion of students at the B.M.S. level, then our Final M.B. results would correspondingly improve. Some other schools prosecute a more rigorous selection process for the clinical course and this may explain why their results are better. This suggests two ways we could immediately improve the situation. If our main aim is to achieve a high pass rate at the Final M.B. we could facilitate this by a higher fail rate at the end of the B.M.S. course. On the other hand, if we aim to ensure a high proportion of students qualifying upon completion of their course we could identify those who did least well in the B.M.S. examination and encourage them to take the Conjoint as well as the Final M.B. examinations.

In the immediate future your editorial rightly draws attention to the need for more formal preparation for the Final examination during the last medical and surgical firms and this is something we must try to organise by next summer. As for your strictures about the results of the examination in surgery, I am sure the surgical teachers are as aware as the students of the need to see if the results can be improved. In this context it must be stressed however that the failures this year (21) were of the same order as previous years; the numbers failing surgery over the past five years have been 21, 20, 28, 32, 22. The problem, once more, is not that there has been a sudden change in results, but the low numbers taking and passing the Conjoint examination has revealed our historically low M.B. pass rate.

The combination of a school-based clinical examination, a higher B.M.S. fail rate and encouragement for weaker students to take the Conjoint examination could solve the problem, but clearly these policies will need further debate and agreement before they can be implemented.

Yours faithfully,

TIM CLARK,
Sub-Dean.

Guy's Hospital,
London, SE1 9RT.

Surgical Firms Outside Guy's

Sir,

May I take this opportunity to congratulate you on your Passim of the last issue. Perhaps I could also endorse your two most important conclusions.

First the failure rate in surgery is unacceptably high. Half of the students go to Lewisham for eight weeks; but perhaps the other half might be given the opportunity to work in a busy surgery department where on take-in (a 1 in 2 rota) they will see at least six patients.

Secondly, that a revision course in exam technique be instituted. At University College they are well versed in aspects of exam technique and the failure rate is considerably lower than ours. This need not be a formally organised course for all students but facilities (willing staff) should be made available for students to study radiology, common surgical problems, and patient management, etc. This should become common practice in the last two firms.

It is quite true that twenty-two students failed to qualify. However this number is not significantly higher than in previous years. The percentages (37% in surgery) are much higher because there were fewer students taking the exams. More students from that year opted for an intercolated B.Sc. than usual and will take their finals next year. That left a higher proportion who were perhaps not quite as competent at passing exams. In short these results are not startlingly different from previous years.

But in no way does that lessen the validity of your conclusions, in fact it reinforces them. If over a number of years the results have been consistently poor then education in exam technique must be long overdue.

The surgery results are consistently bad and therefore improvements must be introduced quickly—a *laissez faire* attitude is not going to activate the problem.

Another surgical firm outside Guy's must become, if it is not already, top priority. It may be difficult and it may not be politically expedient—but it obviously has become essential.

Yours faithfully,

DAVID DENNING.

Sir,

After the war Mr. Piper was commissioned to paint a beautiful picture of Old Guy's House which now hangs in the Clubs' Union of the East Wing. It is understood that coloured prints derived from this picture could be made available if there was sufficient interest. In order that this can be measured I would be glad to hear from Guy's men and women about this matter. Please write to the above address. Very generously Mr. Piper has indicated his enthusiasm for the plan, and has promised to do what he can "to advise and help the preparation of a suitable print". Characteristically he ends —"I would not wish to make any money out of it."

Yours faithfully,

ARTHUR WILLIAMS.

82 Banbury Road,
Oxford, OX2 6LG.

Cricket Casualty

Sir,

The cricket fixture between Guy's and Cuckfield has now lapsed, another casualty resulting from the closure of "Thatchings" and economic stringencies in general. Since the first game against Mike Morgan's team we have enjoyed a series of contests, some even starting on time, and many happy, albeit half-forgotten, evenings.

The balance of power was with Guy's in the early years, especially against the splendid sides of the early 1960's, when Guy's regularly reversed the batting order. In later years, however, Cuckfield sides had their moments and we once won by an innings employing the spinners only after tea. I could fill a book with reminiscences.

The fixture originated in 1958 on the Thursday after the Bognor Tour weekand as part of the Cuckfield Week. Last year, the presence of the sons of Mr. F. N. Glover and my contemporaries Drs. David and Prue Tunnadine reminded me how time was getting on.

May I thank the many cricketers who have visited us over the twenty years for their contribution towards the happy matches that have been played. And if the laws of libel are changed I might still write that book!

Yours faithfully,

W. A. CAHILL.

Woodford,
Cuckfield Lane,
Warninglid, Sussex.

SPORT

SPORTS REPORT

The summer is over (if it was ever here) and the time for sloth is past. The hours of apathy and indolence encouraged by the heat of the sun in the sky have ended. Over is the time when the only exercise you take is to move the deckchairs outside (or inside when it rains) or get angry over the telephone trying to book a late holiday. Here is the beginning of autumn. I suggest a gradual return to fitness by enjoying a slightly more relaxed activity —have you tried that most noble of pursuits, rowing? May I suggest a few rough guidelines for your new sport?

Did you know that Guy's has a rowing club? Nay more, it has boats *too*! The University of London has its own boathouse in Chiswick where it houses boats from many of the teaching hospitals. A short journey on the train from Waterloo and a shorter walk from the station at Chiswick and you have arrived.

You may like to try and find the Guy's boats, but I'm afraid to say they were broken when we went. However, Mary's Hospital though not prolific rowers have plenty of cash for boats so we borrowed one of theirs. For novices there is a practise pool where it is possible to try the complicated art of rowing. I do not recommend that you try these as the experts may hurl you into the smelly pool water if you fail to make adequate progress. So bluff them all and get the boat straight onto the river. You will need four or eight persons and a cox. I'm an M.C.P. and recommend a pretty female cox with nice legs. The cox's job is to call time and keep you amused with jolly jokes while she steers. Unfortunately most coxes I know have a nasty streak and insist on numbering you according to your position in the boat and humiliating you frequently. She may insist on the best looking of you sitting at the front end stroking. This does not mean that he spends his time fondling her legs but the stroke is the metronome to which all rowers keep time.

Now you are on the river tied firmly to the boat by your feet. This is essential to prevent you being swept overboard when you "catch a crab"). (I spent ages searching the end of my oar for this beast before someone explained this allegory to me.) Rowing with the tide is one of the most splendidly exhilarating things you can do. Of course when you turn round and have to try to get home sometimes the desperation is hard to prevent. If your cox is a good amateur psychologist he will make you row harder by further humiliating you and thus making you angry.

When you finally arrive back at the boathouse sweaty, tired and badly blistered you have to empty the water out of the boat. If when you look inside, there is not too much water inside you may like to "throw the boat". This involves bouncing the boat three times on the water calling the time loudly to attract attention and then tossing it into air with a wild cry and holding it above your head at arm's length. As the water dribbles down your arms and into your shirt you will feel acutely uncomfortable especially if you underestimated the amount of water in the boat, but the whole procedure is most effective and may get a few gasps of amazement or even a ripple of applause. Well worth the effort especially for impressing crews of the opposite sex! The last task is to decide on a goof for the day, usually the chap who splashes and wets everyone when he rows, and hurl him into the Thames. You must warn him about inhaling the water as this usually needs rapid hospital admission. The celebrated Tom Allun-Jones was concentrating on this so hard that he cut his knee and this went so badly septic he could only hobble for days.

Of course all this mild exertion is only an excuse for a celebration afterwards. The clubhouse serves a good tea quite cheaply and even warm Whitbread Tankard if it is late enough. On the way home there are two essential stops. The first is a splendid pub just before the station at Chiswick where you can drink and wait for a train. Why is it the trains always arrive just after the first sip of your pint? Secondly there is the Hole in the Wall next to Waterloo Station, a hostelry well loved by sportsmen of all kinds where a good time and splendid refreshment is guaranteed to all.

So next time you see five or nine people causing a rumpus on their way home at Waterloo Station late at night, you may assume exactly what they have been doing.

JONATHAN EARNSHAW.

GUY'S CRICKET TOUR

Guy's cricket club's tour of Bognor Regis was somewhat curtailed this year due to Pagham being on tour themselves, and the usual reason, "summer"—rain.

Somehow ten of us managed to arrive at Bognor by 2.15, after several members of the team had to assist a psychiatric S.H.O. battling halfway down St. Thomas's Street with a decidedly stroppy alcohol patient with D.T.s.

With the addition of a local worthy to our side Guy's fielded rather averagely as Bognor reached 186–6 (Jacks 4–36) mostly due to one batsman, highly unlucky to be caught by Dick Sheridan for 93.

In reply Guy's did their usual trick—Ryan 7, Hughes 7, Mitchell 1 (bad luck, Andy!), Shepherd 9, reaching 50 for 7 before Sheridan (23 not) and Senior (14) took our score to a respectable 103 all out, Clive Paul narrowly failing to heave his third ball out of sight.

We repaired to the Ancient Mariner—a maze of stairs and narrow corridors when one isn't sober, which was ideally situated on the front near the Indian restaurant, American Burger bar, dreadful Cypriot nightclub and putting green, for darts and ale.

Monday being a rest day, Hughes and Glover completed a round of golf before causing extreme embarrassment to a bunkered team-mate at the 18th.

The rest of the side performed near miracles at beach cricket, none less than Clive Paul (a comparative newcomer to the game) who managed an immaculate −42 (Yugoslavian laws).

Back at the Mariner a very drunk Glover failed to impress on the darts board, being "killed" by an unknown paraplegic previously unable to make contact between dart and board.

Our game against Brighton Hospitals at Bevendean was high scoring despite the small ground. We batted first and after a solid start from Mitchell (26) and Leonard (11) accelerated rapidly through Glover (39) and Hughes who at the declaration had made 146 not out (10 sixes) out of 251 for 8.

In reply Brighton got off to a good start reaching 117–3. Using off-spin from both ends we narrowly failed to bowl them out with the final score 228–8 (Glover 5–92, Hughes 2–72).

In the Indian restaurant afterwards, "Don't give anything away" Senior expressed his liking of a sort of Indian hot-pot in the phrase "Eh, I like this sort of curried robust stew-type preparation (in broad Yorkshire) but followed it with a characteristic "Oh b-gg-r" after his first bite.

Bognor's talent being what it is, absent, we returned once more to booze and "killer".

Wednesday's game at Middleton was unfortunately washed out and so the tour came to a premature end.

Our thanks to the proprietors at the Ancient Mariner for their kind hospitality.

"JADES."

Guy's Dry Fliers Flying Low

There were showers, and more than a little wind, when the newly formed Guy's Dry Fly Fishing Club challenged the Fly Fisher's Club of London to a test of skill on the River Avon on August 25th. The Guy's squad were captained by Adrian Weston (Sir Adrian to his friends) who is disputedly one of the finest dry fly fishers in British hospital medicine. It was unfortunate, then, that though the Guy's fishermen showed great skill and adaptability throughout the match, their efforts were not rewarded by a like proportion of success.

The match was held by courtesy of Lord Finsley, on his 1½-mile stretch of the Avon, and it was Lord Finsley's champagne that was liberally offered to the three members of each team before the match began at 8.00 a.m. Adrian offered to postpone the competition till the afternoon as there seemed little chance that a dense fog that was covering the river valley would clear till midday, but the other five fishermen were against this. In a way he was lucky that they did, as he won the toss, and chose his team to cast with the wind. Though it was a day for the under-water nymph if there ever was one, Adrian, who is one of the few remaining complete dry fly purists left, suggested that only floating flies should be used; a decision that considerably upset his team-mates Christopher Parker and Dick Reading. Nevertheless it is doubtful whether the outcome would have been any different had Adrian decided otherwise.

The captain, himself, had a rather unhappy day, which was not helped by drawing one of the least promising stretches on Lord Finsley's water; a slow moving piece, which was virtually covered in weed. Nevertheless he persevered, using mainly Black Gnat and Silver Sedge, and the sheer deftness with which he used his new Hardy's "Perfection" split cane rod, while smoking his familiar pipe or sucking Fisherman's lozenges,

was a great delight to the few onlookers. He hooked his first fish at 3.00 in the afternoon on a Black Gnat, but the fish headed straight for the weed, and before Adrian was able to wade in to disentangle it, the fish had been lost. The same happened with a good fish some minutes later, which instigated a steady flow of abuse that shocked the onlookers, and was only curtailed when the attractive but obtainable Lady Jane Finsley brought round the tea-time champagne cocktails.

Chris Parker, who is far from inexperienced, had an even less successful day, which may jeopardise his chances of being in the team next year. He had a relatively nice stretch with plenty of fast runs, but appeared nervous and even quite angry for a large proportion of the day, which he spent disengaging his erring fly (mostly Black Alder and spent Olive Dun) from trees, his left gumboot, and, even at one point, Lady Jane Finsley's windcheater.

The big surprise of the day, however, came from Dick Reading. A relative new boy to the game, having cast to his first rise only three months ago, he was the only member of the Guy's team to catch anything at all. His inexperience was obvious, both in his short casting and his choice of fly (a number 14 hook Terry's Terror) but he used what he had well. Nevertheless it was well into the afternoon, when he hooked a 1¼lb. brown trout (only his sixth he claims). In a beautifully handled fight with the fish, which seemed at one point to be heading for the dense weed on Adrian's stretch, Dick showed a potential which will spoil the post-port drinking atmosphere in the London Fly Fisher's Club for some time to come. He finally netted it, and well pleased with his success stopped fishing for the day, and joined Lady Jane on the river bank. There was, nevertheless, a lingering doubt among some spectators that Dick (he's not called "Dirty" for nothing), who spent a large proportion of the day behind a tree with a spade, may have been smuggling garden flies (worms) onto his Terry's Terror.

In the end the result was not a totally ignominious one: Guy's 1¼lbs., Fly Fishers of London 7⅜lbs. Clearly Guy's will have to get some practice in before they repeat this event, but as Adrian joked after the match "the result wasn't much worse than the Guy's Finals results, and rather more expected".

If anyone would like to join the Guy's Dry Fly Fishers Club please apply to Adrian Weston, East Wing.

M. D.

The Consultants' Golf Match

This is a traditional meeting which has taken place annually since before many of us were born. Most readers will have little idea of the proceedings. It consists of 36 holes of golf "doubles" or foursomes, each partner hitting alternate shots. The 36 holes are split into two to accommodate lunch and heavy refreshments.

So, annually ten consultants, chosen by their present society President, Professor Trounce, show lesser beings of the medical hierarchy the finer points of the game; which of late they have done regularly.

The venue is Huntercoombe in Oxford, absolutely the perfect setting (towards Nuffield, turning left at Nettlebed!), and if we weren't rushed to get there on time with an incomplete team, the tempo would have soothed any troubles, failing that, the general good humour which invariably marks this occasion certainly chased away visions of the Monday to come.

So it was on Saturday, July 1st we met in the quad and drove (eventually) a not inconsiderable distance to set battle.

If I recollect correctly, we only won one match and drew another out of 10. Ah well, everyone enjoyed themselevs, long live tradition and they haven't a hope next year! Famous last words? We'll see.

The club wishes to congratulate the Professor for organising his team and wish him success in his capacity as President which I'm sure he enjoys. Lastly, the club apologises for its lack of punctuality at the above fixture and I trust that, in future, we will have a full team of dedicated players.

Participants were:—

Go. Palmer, W. Whitby, M. Craigen, N. Page, R. Kirk, I. Nicholson, J. McArthur, R. Heard, S. Matthews.

Prof. Trounce, Dr. Houston, Mr. Coltart, Dr. Hewitt, Mr. Brain, Dr. Maclean, Prof. Cohen, Mr. Joyce, Mr. Lawrence.

Stuart Matthews, Secretary.

HOSPITAL INFORMATION

PAPERS BY GUY'S MEN

Alexander, M. D., Andrews, J. A., Leslie, R. C. Q. *and* Wood, N. J. The binding of human and guinea-pig IgG subclasses to homologous macrophage and monocyte Fc receptors. **Immunology,** 1978, **35,** 115.

Ashley, F. P. *and* Wilson, R. F. The relationship between calcium and phosphorus concentrations of human saliva and dental plaque. **Archives of Oral Biology,** 1978, **23,** 69.

Bingham, J. B. *and* Maissey, M. N. An evaluation of the use of $^{99}Tc^{m}$-dimercaptosuccinic acid (DMSA) as a static renal imaging agent. **British Journal of Radiology,** 1978, **51,** 599.

Bridges, P. K. The physiology of mental stress: some practical aspects. **Journal of the Royal Army Medical Corps,** 1978, **124,** 75.

Cohen, S. Development of a malaria vaccine. **Journal of the Royal Society of Medicine,** 1978, 71, 476.

Corrigall, V., Panayi, G. S., Ungar, A., Poston, R. N. *and* Williams, B. D. Detection of immune complexes in serum of patients with ankylosing spondylitis. **Annals of the Rheumatic Diseases,** 1978, 37(2), 159.

Dalton, E. R. The use of a questionnaire on medical terms as a teaching tool for medical students. **Medical Education,** 1978, **12,** 191.

Davies, P. M. Smooth Muscle Tumours of the Upper Gastrointestinal Tract. **Clinical Radiology** (1978), **19,** 407.

Fine, J. Medical Fitness to Drive. **Disabled Drivers Motor Club Yearbook,** 1978.

Fisher, M. A., Hendrix, T. R., Hunt, J. N. *and* Murrills, A. J. Relation between volume swallowed and velocity of the bolus ejected from the pharynx into the esophagus. **Gastroenterology,** 1978, **74,** 1238.

Gardiner, P. A. Vision screening in children. (Correspondence.) **British Medical Journal,** 1978, **2,** 54.

Jourdan, M. H. Oxprenolol in the operating theatre. (Correspondence.) **Lancet,** 1978, **2,** 111.

Lessof, M. H. If I were director of the N.H.S. **Lancet,** 1978, **2,** 27.

Lessof, M. *and another.* Immunological mechanisms in health and disease. **Medicine (U.K.),** 1978, *3rd series (1),* 37.

Mainwaring, P. J. *and* Naylor, M. N. A three-year clinical study to determine the separate and combined caries-inhibiting effects of sodium monofluorophosphate toothpaste and an acidulated phosphate-fluoride gel. **Caries Research,** 1978, **12,** 202.

Maisey, M. N. Nuclear medicine—2: Liver and spleen scanning. **Hospital Update,** 1978, **4,** 459.

Mallinson, C. N. Gastroenterology. **Update,** 1978, **17,** 269.

Maynard, J. Submandibular and parotid gland resection. **British Journal of Hospital Medicine,** 1978, **20,** 70.

Meredith, T. J., Newman, B. *and* Goulding, R. Paracetamol poisoning in children. **British Medical Journal,** 1978, **2,** 478.

Parsons, R. L., Beavis, J. P., Laurence, M., David, J. A., Paddock, G. M. *and* Trounce, J. R. Plasma, bone, hip capsule and drain fluid concentrations of ampicillin and flucloxacillin during total hip replacement after intravenous bolus injection of Magnapen. **British Journal of Clinical Pharmacology,** 1978, **6,** 135.

Pearce, J. B. The recognition of depressive disorder in children. **Journal of the Royal Society of Medicine,** 1978, **71,** 494.

Polani, P. E. Screening for neural-tube defects. (Correspondence.) **Lancet,** 1978, **2,** 216.

Rebello, T. *and* Hawk, J. L. M. Skin surface glycerol levels in acne vulgaris. **Journal of Investigative Dermatology,** 1978, **70,** 352.

Robinson, B. W. S. *and* Corless, D. Spurious polycythaemia resolving during observation. (Correspondence.) **British Medical Journal,** 1978, **2,** 280.

Rogers, H. J., Morrison, P. J. *and* Bradbrook, I. D. The half-life of amitroptyline. (Correspondence.) **British Journal of Clinical Pharmacology,** 1978, **6,** 181.

Ross, D. N. *and another.* Successful surgical repair of solitus, dextrocardia, atrioventricular discordance, and double outlet right ventricle with 1-malposition of the aorta. **European Journal of Cardiology,** 1978, **7,** 105.

Simmonds, H. A. Career structure for non-medical scientists. (Correspondence.) **Lancet,** 1978, **2,** 321.

EXAMINATION PASS LIST

ROYAL COLLEGE OF SURGEONS OF ENGLAND

F.R.C.S.

B. J. Holdsworth
N. F. Hopkins
P. A. N. Hutton
M. P. Stearns (Otolaryngology)
J. A. Dick
M. J. Timmons
A. J. Cook
P. G. Reasbeck

Fellowship in Dental Surgery

R. E. Hickman

UNIVERSITY OF LONDON

Faculty of Medicine

Preliminary Examination for Studies in Medical Subjects

C. I. Bartlett
M. Batterbury
G. N. D. Cowland
M. A. Foley
S. M. Ginnity
E. C. Hancock
T. R. Lancaster
M. F. M. Leigh
K. R. Lloyd
S. K. McDonald
J. F. X. Rawcliffe
P. C. E. Sartori
J. M. Shaw
A. G. Spencer
E. F. Storr
F. Thomas
A. P. T. Tresidder
C. E. Yeates

Ph.D.—Science

Z. Sayers (Physics)

Ph.D.—Medicine

M. M. El Din Ata Elmazar (Pharmacology)
Jean Mary Cooper (in Human Communications)
R. E. Vargas-Arenas (in Pathology)

M.B., B.S. Examination in Basic Medical Sciences and Pharmacology

D. J. Bailey
J. R. Balazs
A. C. Barraclough
A. S. Black
J. M. H. Bolton
A. Boucherat
R. J. Bowes
D. B. M. Brooke
A. R. Brookes
D. Chai Tuck Cheun
J. M. Chaloner
A. J. Charters
P. Clayton
S. L. Cohen
P. A. J. Collings
G. P. Cook
P. J. Coppock
M. P. Corlett
F. P. Cowmeadow
M. A. C. Craigen
T. P. Cullinan

C. R. Darby
M. D. Davies
S. V. Davies
A. J. Dawton
G. Denton
D. E. Fish
N. A. Fletcher
L. M. L. Flower-Hill
B. A. L. Foulger
P. J. Galbraith
A. P. Gallas-Gajasy
M. J. Grande
N. G. Grecas
K. J. Harper
D. Hastings-Nield
L. M. Herrington
T. D. Houlding
W. L. Hughes
M. E. Illingworth
P. A. Jackson
T. R. Jennings
K. L. John
P. D. Kapff
A. M. Kerslake
J. S. Kerslake
I. G. Kestin
N. I. Konzon
R. R. Lalsarin
J. A. Langton
V. M. Laurence
G. Lewis
M. Llewellyn Smith
D. C. Lucas
C. A. K. Y. Mok
S. P. G. Moore
R. H. Long
A. W. Longmore
J. W. T. Lovett
N. J. Murrant
J. L. Nowottny
M. O'Driscoll
J. A. Oliver
C. V. Orr
H. W. Orridge
S. E. Paget
T. A. Palmer
B. S. Pilkington
M. Powlson
J. G. Powney
S. Rawstorne
K. A. Richmond
P. D. Robinson
G. A. Russell
A. N. Sawyer
E. J. Scott
D. S. Smalley
P. W. Soothill
C. K. Stanley
V. Sundaresan
J. A. Taylor
W. R. J. Taylor
S. E. Thomas
T. J. Thurston
C. H. J. Tunnadine
E. F. Vallance
D. N. Wallis
E. J. Walter
G. E. Wilcox
G. Yau Hok Man

Final M.B., B.S.

J. P. M. Evans
M. J. F. Humphries
R. M. Atkins
D. Beswick
V. J. Bolton
N. V. Boyes
A. S. E. Bristow
S. J. Comper
D. F. Dayson
K. J. Dismorr
I. R. A. Duckworth
C. P. Gilford
R. G. T. Glynne-Jones
J. A. Hancock
M. C. Harrison
N. P. Hirsch
J. R. Hogg
A. Holden
M. C. Hollway
M. W. Houghton
P. J. Howard
P. J. G. Hutchings
A. K. P. Jones
D. E. Jones
G. J. A. Joy
A. J. M. Lalor
A. G. Long
S. E. Perfect
G. A. Shun-Shin
S. J. Sperring
G. J. Tamlyn
R. M. Terry
R. T. Thompson
W. P. Towell
C. C. Trounce
A. T. Tylee
G. C. Vafidis
D. K. H. Webb
J. S. Westbury
W. S. Whitby
D. L. Williams

Final M.B., B.S.

Part V

J. S. Aldis
N. J. Barrie
F. M. M. Campbell
I. D. Crate
J. P. Findlay
M. W. Gill
M. J. E. Higgs
J. W. Mason
H. J. Milburn
D. M. Mitchell
J. W. A. Moore
B. Newmarch
T. C. Owen
I. J. Page
J. Rockall
R. D. C. Southwell
S. Q. M. Tighe

Part VI

J. S. Aldis
F. M. M. Campbell
I. D. Crate
J. P. Findlay
S. J. Forsdick
M. W. Gill
M. J. E. Higgs
H. J. Milburn
D. M. Mitchell
T. C. Owen
J. Rockall
R. D. C. Southwell
S. Q. M. Tighe

Part VII

D. M. Mitchell
J. W. A. Moore
B. Newmarch
N. J. Barrie
F. M. M. Campbell
A. B. E. Clark

Part VIII

J. S. Aldis
J. P. Findlay
S. J. Forsdick
M. W. Gill
A. R. A. S. Hamid
M. J. E. Higgs
J. W. Mason
H. J. Milburn
T. C. Owen
H. W. Pritchard
J. Rockall
R. D. C. Southwell
S. Q. M. Tighe

Second Examination in Dental Surgery

R. A. Baker
C. E. Berry
T. W. Biddle
D. S. Brampton
J. J. W. Breckon
G. M. Burr
S. C. Burrows
L. Burson
D. S. T. Carr
P. D. Cheshire
S. M. Clark
S. Clark-Hall
G. J. Clement
N. M. Coppock
M. I. Cotgreave
M. A. Cronshaw
S. C. Davies
E. D. Deacon
R. A. Dubbins
N. Elvin
D. Flanagan
M. J. Fogg
M. J. Fox
M. A. C. Foxton
M. J. Gealer
H. M. Giel
I. H. S. Gillespie
K. A. Grave
S. L. Green
S. D. Gregson
G. Habberfield-Bateman
K. E. Harley
A. J. Hart
J. W. D. Hooper
J. M. Irons
S. Jagsi
E. A. Jenkins
J. Jenkins
S. P. Knights
N. J. B. Lodge
M. N. Lowey
C. Marshall
G. B. Martin
A. Mehta
K. G. Middleton
B. A. Milne
C. N. T. Mitchell
N. S. Mudhar
G. M. Nobbs
J. C. Pennington
L. A. Phillips
A. M. Portelly
D. R. Radford
L. S. Schaller
P. A. Stephenson
G. H. P. Suchett-Kaye
C. A. Thomas
R. D. L. Thomas
A. G. Vaughan
D. R. Webber
Wee Kha Koon
J. A. E. Williams
L. J. Winchester
J. P. Wise

Third (B.D.S.) Examination in Dental Surgery

Honours: S. J. Thomas

Pass:

P. I. Arnold
J. P. A. Cooper
R. P. Ingham
J. A. Ingram
N. Lolley
H. J. Longton
T. D. U. Miller
N. S. Singer
J. E. Taylor
C. J. Mitchell
M. R. Owen
A. J. Patching
R. M. Piper
J. M. Ryan
S. R. D. Saunders
S. I. Wallis
S. E. Ward

Part I

R. P. Adams
S. L. Aldrich
M. E. Arthur
G. K. W. Au
K. E. Barker
G. L. Bell
S. Berry
C. S. Bhat
C. W. Brazenall
M. R. Breeze
R. D. Browne
N. C. Burton
W. J. Byrd
P. K. Downes
J. R. Exelby
S. P. Fenny
S. Filby
P. R. W. Goslin
D. I. Greenaway
C. Hall
R. N. Hayes
P. S. Hockley
P. J. Holmes
J. M. Horsfield
D. R. E. Jones
N. Z. Junid
N. G. Kingdon
W. P. Kwok
H. C. Lane
J. A. Lewis
R. A. Loukota
M. D. MacEvoy
M. J. Newport
R. M. Nicholas
J. M. Olding
D. S. Osborne
M. G. Pascoe
J. H. Phelps
S. Raichoora
R. G. Robertson
S. N. Robinson
N. S. Sehmi
P. J. Silvester
D. Squire
M. Ullrich
A. Varma
J. D. Watson
T. F. Watson
R. Wellington

Part II

L. A. Brereton
A. L. Buck
M. J. Crawley
J. M. Ede
E. M. George
M. E. E. Griffiths
S. N. Gulamali
J. A. S. Harrison
R. S. Levy
A. A. Matheson
D. A. H. Pacy
D. A. W. Puckeridge
S. K. Robinson
A. J. Smith
B. M. Wilmers

Part III

S. I. Baxter
J. E. M. Bellringer
L. A. Brereton
A. L. Buck
H. M. Chryssides
N. G. Cliff
M. P. Cornelius
P. S. Freiberger
M. E. E. Griffiths
S. R. Griffiths
A. J. Marks
G. D. Palmer
J. A. Pascoe
S. K. Robinson
A. H. Strachan

Part IV

N. V. J. Barrett
N. S. Bhuva
E. V. Bosch
A. V. Bramwell
N. J. Capp
J. E. Carr
S. J. Carter
V. J. Cater
N. P. Chandler
Chen Chun Kit
D. I. Christopher
J. M. Colley
M. J. Crawley
G. V. Cresswell
T. M. Day
S. A. Des Clayes
C. Dixon
J. M. Ede
A. M. Edgington
M. Fillery
J. M. Friend
G. M. Gauntlett
R. W. Gilbert
M. A. W. Habib
M. Hammond
K. M. R. Harrison
F. J. Hughes
J. A. Jordan
C. N. Kay
C. J. Legg
A. C. B. Loige
M. A. B. McEvedy
C. H. Macfarlane
F. M. McLean
A. J. Marks
N. L. Matthews
T. A. T. Nguyen
J. A. Owen
D. A. H. Pacy
J. A. Pascoe
S. G. Perkins
S. M. Perry
A. G. Pigot
S. L. C. Pimm
A. P. J. Pini
R. B. T. Price
D. J. C. Rees
A. J. Renaut
G. D. Rickard
R. Saravanamuttu
A. E. Searle
J. E. Sladden
J. G. Smerke
A. J. Smith
G. T. Smith
N. R. Smith
P. A. Sugden
F. Suleman
G. D. Tarrant
C. D. Thomas
P. Vohra
K. Warren
A. J. Watson
D. J. Watson
N. P. Willis
K. L. Worrell

State Final Examination
July, 1978

List of Successful Candidates:—

M. M. Arthur
A. Beswick
K. E. Booth
S. C. Brooks
S. E. Cawood
G. J. Charlesworth
A. Clinckett
J. B. Cox
E. V. Drosso
D. C. Ford
J. L. Hambrook
E. M. O'Kelly
H. A. Prior
R. M. Rawcliffe
I. Schofield
S. G. Scripps
E. H. Smith
K. M. Sutherland
E. Theaker
S. R. Wigglesworth
S. F. Williams
V. H. Wills
J. M. Donlevey
A. E. Howse
U. M. Leavy
J. K. Mager
E. A. Smith
E. C. Yeomans

THE CHARTERED SOCIETY OF PHYSIOTHERAPY

Final Pass List—July 1978

Mrs. F. Bondarenko
Miss G. A. Dobson
Miss C. P. Kinloch Jones
Miss M. Marstrand

Part II Examination—June 1978

Miss R. A. Birse
Miss D. M. Blacker
Miss M. Boase
Miss E. A. Leftley
Miss C. J. Mackenzie
Miss J. L. May
Miss A. M. Capstick
Miss A. P. Chown
Miss S. J. Christie
Miss S. C. Davie
Miss A. M. Davies
Miss A. S. Davies
Miss L. B. Frost
Miss S. M. Gaastra
Mrs. S. V. Gray
Miss B. Rees
Miss K. M. Roe
Miss J. S. Schurr
Miss Y. Sidebotham
Miss K. M. Smith
Miss S. Stacey
Miss E. J. Thompson
Miss P. M. Williams

SENIOR HOUSE APPOINTMENTS

Renal

(S.H.O.) Dr. A. H. Gershlick 1.6.78–30.11.78
(S.H.O.) Dr. M. Bamber 1.9.78–28.2.79

Thoracic

(S.H.O.) Dr. D. V. Skinner 1.7.78–31.12.78
(S.H.O.) Dr. T. Govindasamy 1.9.78–28.2.78

Anaesthetics

(S.H.O.) Dr. N. D. Bardsley 1.7.78–30.6.79
(S.H.O.) Dr. T. M. Baylis 1.10.78–30.9.79
(S.H.O.) Dr. J. Glover 1.9.78–31.8.79
(S.H.O.) Dr. C. Carnegie 1.9.78–31.8.78
1.9.78–31.8.79

Neurology

(S.H.O.) Dr. K. B. Elkon 1.9.78–28.2.79

Dermatology

(S.H.O.) Dr. J. J. Horton 1.9.78–28.2.79

Nuffield

(S.H.O.) Dr. J. S. M. Tidman 1.9.78–28.2.79
(S.H.O.) Dr. W. C. Crozier 1.6.78–30.11.79

Casualty

(S.H.O.) Dr. C. B. Ackner 1.9.78–28.2.79
(S.H.O.) Dr. R. S. Hurwood 1.9.78–28.2.79
(S.H.O.) Dr. R. P. Money 1.9.78–28.2.79
(S.H.O.) Dr. J. R. C. Heyworth 1.9.78–28.2.79

Paediatrics

(S.H.O.) 1.10.78–30.9.79 Dr. L. A. Broughton
(S.H.O.) 1.4.78–30.11.78 Dr. R. A. McCubbin
(S.H.O.) 1.6.78–31.1.79 Dr. J. R. Bayly
(S.H.O.) 1.6.78–30.11.78 Dr. R. Jukes
(S.H.O.) 1.9.78–31.3.79 Dr. J. S. G. Bamforth
(S.H.O.) 1.12.78–30.11.78 Dr. A. E. Brusby
(S.H.O.) 1.1.78–31.1.79 Dr. T. G. Powell
(S.H.O.) 1.3.78–31.3.79 Dr T Y. D. Leung
(S.H.O.) 1.6.78–31.5.79 Dr. A. C. Walsh
(S.H.O.) 1.8.78–31.7.79 Dr. M. Cromie 1.10.78–30.9.79

BIRTHS

EVANS—to Leonora and Edward Evans on 26th July, 1978 in Cape Town, a daughter, Melanie Christine, a sister for Richard.

ENGAGEMENT

The engagement is announced of Mr. Peter James Holmes, dental student, to Miss Joanna Wilkinson.

MARRIAGES

Christopher F. Sharp and Sarah M. Cripps (Guy's '72–'75) married in Bosham, Sussex on 20th May, 1978.

Mr. Graham Watts and Rosamond Troughton, B.D.S. are to be married on the 18th of November.

DEATHS

Mr. Stanley Tinkler, L.D.S., died on 19th June, 1978.

CHANGES OF ADDRESS

Mr. H. Fletcher Lunn, F.R.C.S., Whiterock, Gorton Alister by Brodick, Isle of Arran, Scotland.

Mr. R. Morris, B.D.S., L.D.S., R.C.S., Spange Hawe, Pitch Hill, Ewhurst, Surrey. Tel. Ewhurst 582.

Dr. and Mrs. N. J. Odom, Flat 4, 2 Holmesdale Gardens, Hastings, Sussex.

Mr. and Mrs. C. F. Sharp (née Cripps), 9 Richmond Park Road, 2nd Floor Flat, Clifton, Bristol, BS8 3AS.

Mr. H. F. Thomas, B.D.S., L.D.S., R.C.S., 800 Babcock Road, Apt. G4, San Antonio, Texas 78201, U.S.A.

From 18th November Mr. and Mrs. Graham Watts will be at Whitethorn Cottage, 46 Meadow Lane, Little Houghton, Northampton.

PERSONAL

THIRD PARTNER—required by general practice. Retirement of Senior Partner. Purpose-built premises. Attached Health Team. Drs. Hunt and Goodhart, 1a Pope Road, Bromley, Kent.

CHANNEL ISLANDS—Guy's trained, English, G.P. with seven years experience in practice; disillusioned with contraints of N.H.S. seeks opening in Channel Island practice. Connection with Guernsey. Some capital available. Telephone 0480–890049.

FOR SALE—Town House, 3 beds, ideally situated for Guy's, King's, Dulwich, New Cross. Between One Tree Hill and Brenchley Gardens. Contact Martin Mace, Dept. of Oral Surgery.

We should like to remind our readers that all copy for inclusion in the "Gazette" *must be received 12 days before publication.* Copy dates for the next 2 months are: 16th October and 20th November.

Copy may be sent to us at 16, St. Thomas Street, S.E.1.

Birth, Marriage, Death and Change of Address notices are inserted without charge to subscribers.

When subscribers notify the "Gazette" of Change of Address, would they please indicate whether or not this should be published.

Personal notices are charged at 10p per word (pre-paid, minimum £2.00).

Non-subscribers are charged £2.00 (pre-paid) for all notices other than Death.

GUY'S HOSPITAL GAZETTE

ISSN : 0017-5870 Tel. No.: 01-407 7600 Ext. 2023

EDITOR ADRIAN PINI
ASSISTANT EDITOR PHILIP RAZZELL
NEWS EDITOR CAMILLA HAW
SPORTS CORRESPONDENT JONOTHAN EARNSHAW
NURSING CORRESPONDENT PAMELA JEFFERIES
PHYSIOTHERAPY CORRESPONDENT RONALD COOPER
MANAGER LYN PAYNE
ADVERTISING MANAGER JONATHAN BARKER

MONTHLY 28 OCTOBER 1978 VOLUME 93 92 NUMBER 2286

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

PASSIM

The future of Guy's Sport

Sport. What does it mean to us at Guy's? For the average student very little it would seem. Little more than the hot, sticky summer of spectacle on the box—unending hours of huffing, puffing and straining from Montreal, Edmonton and Wimbledon. In short, something to be gazed at from the comfort of an armchair, in breaks between intense swotting for that incessant round of medical and dental examinations.

Today it is common knowledge that there are an increasing number of students who manifest a frankly pathological abhorrence for things sporting; perhaps a function of our selection procedures which place such a high importance on purely academic achievement. This is a very sad thing. Today our lives are shaped by the demands of our training and the idea of giving "sporting service" to the Hospital is moribund. The sentiments expressed by Dr. Reekie (correspondence p. 431) are understandable. Of late the *Gazette* has been obliged to print more bad news than good on the sporting scene, and the Editors entirely concur with Dr. Reekie that bad news should not be a source of amusement or "inordinate pride".

While we agree with Dr. Reekie that the present attitude to sport is a bad one, if we had censored rather than edited the columns to which he refers he would not have been in the position to write his letter. Ignorance is bliss perhaps, but we feel it is not our job to cover up the appalling state of sport at this hospital, indeed just the opposite.

But not all the news is bad. At this year's Freshers' Fair the sporting clubs were well represented and attracted a good response from many new students. Soccer, for example, is growing in importance and last year both first and second teams were promoted. This year they have a full fixture

list, are running a third team and plan an ambitious tour in West Germany. It is a sign of the times that there are hardly never any Guy's supporters at the matches, though Professor Robinson usually turns out twice a season to cheer the teams on. The Rugby Club can generally boast a small but enthusiastic group of touchline supporters, consisting of wives and girlfriends, but of other students there are pitifully few. The remarkable effect of impressive touchline support perhaps needs to be emphasised, but who can spare the time or summon up the interest to turn out these days?

Where lies the answer? This Hospital has fine sporting traditions of which it has reason to be proud, but our present state is profoundly depressing to anybody who values sport. Here we must admit that the *Gazette* has a vested interest in improving matters, since we realise that many of our valued subscribers are avid and critical readers of our sporting columns. Subscriptions have been cancelled by the poor showing of this or that team! But more than this the *Gazette* has a mission to salvage some Hospital pride, a pride which depends on its sporting achievements, not just exam results—what are all these academic people *doing*?

In the coming months we shall endeavour to report fully and without inordinate pride the good news and the bad, together with details of fixtures and, we hope, suggestions from readers on how things might be improved. It is a small start.

NEWS IN BRIEF

Fire in Works Department

An extensive fire occurred in the works department on the 15th October and as yet the cause is unknown. The building has been left as a shell, all the internal fittings and structures having been gutted by the fire.

Lost in the fire were the electricians and plumbers shops, along with all their tools and equipment. In addition the offices of the works manager and draughtsmen were lost. The majority of the plans of the hospital kept by the works department seem to have been destroyed, but it is hoped to recover some of these when the building has cooled down.

Losses incurred on the ground floor included financial documents, various orders, invoices and requisitions. Fortunately no casualties were reported. Temporary accommodation has already been found, but in the long term it looks as if a new building will be needed to rehouse the works department, which until it is completed will have to make do with makeshift accommodation.

"Gazette" Staff Changes

This month we are pleased to welcome Jonathan Barker, B.Sc. to the post of Advertising Manager. This is our attempt to lift the fortunes of the *Gazette* and ensure that the printer's bills are paid! We wish Jonathan all the luck (and revenue) in the world! We regret to announce the resignation of Stephen Fenny, News Editor, who has given long service to the *Gazette*.

Gilbert and Sullivan Society

Guy's Hospital Gilbert and Sullivan Society will be presenting "Salad Days" by Dorothy Reynolds and Julian Slade with music by Julian Slade. The production will be held in the Greenwood Theatre on Wednesday 13th, Thursday 14th and Friday 15th December at 7.30 p.m. each evening. Tickets will be on sale in the Colonnade and at the door, price 75 pence.

Dental Revue 1978

We are pleased to announce that this year's Dental Revue will be held in the Greenwood Theatre, on Monday 18th December at 7.30 p.m. The Revue will of course be followed by the traditional party.

Further details, tickets etc., will be available nearer the time. Please address any enquiries, etc., to Francis Hughes, c/o Boland House, Guy's Hospital.

Adrian Penney in training for Operation Drake. (Photograph from the local press).

Operation Drake

Adrian Penney has been selected to take part in this expedition which will celebrate Drake's circumnavigation 400 years ago. He will join the expedition next July in Fiji and will be sailing to Papua New Guinea where the expedition will be undertaking zoological, botanical and medical studies in conjunction with local scientific establishments. In particular they will be studying the forest canopy and species diversity in relation to habitat distribution.

The medical programme will include studies of the availability and use of greenleaf food stuffs, measurement of minimal light and visual acuity, threshold, the incidence of vector borne and other endemic diseases, and the measurement of geriatric blood pressure.

Update on Removal of Incinerator Flues

The contractor employed to remove the damaged incinerator flues is now on site and will be here for about 20 weeks.

Some light lifting gear will be used to raise the sections of the main lifting gear to the roof. About 280 rings will then be taken out of the flue shaft and lowered on to the lawn on the east side of the User Tower.

A few of the rings will go to Imperial College for examination and testing, after which a decision will be made on the type of flue to be used for replacement.

Alfred Rycroft Scholarship

Students in their final year are invited to apply for an award from the Alfred Rycroft Scholarship Fund to enable them to spend one month during the summer of 1979 at a Dental School overseas such as the State University of New York at Buffalo.

The value of the scholarship is likely to meet the cost of travel, board and lodging. It should be noted that successful applicants may be required to act as hosts to exchange students from abroad.

Application forms may be obtained from the Dean's Office and should be submitted by 1st December, 1978.

The Sub-Dean of Dental Studies will be pleased to discuss the matter further with any student who is interested and an appointment can be made to see him by ringing extension 3352.

Handel's Messiah

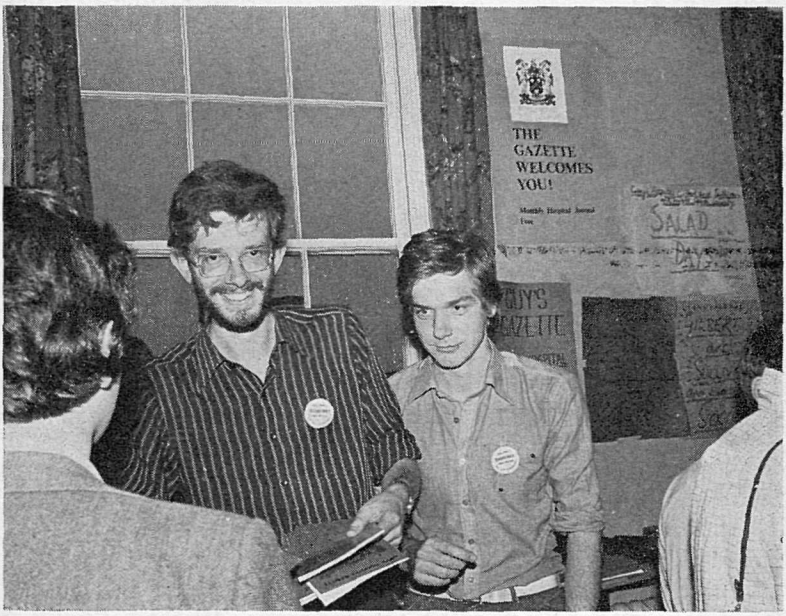
The Music Club will be performing Handel's Messiah in Southwark Cathedral on December 5th and 6th. For any further information please contact the Music Club Secretary (Gina Webb), c/o Boland House Pigeon Holes!

B.D.A. Dentsply Annual Prize

The British Dental Association in conjunction with Dentsply International will again be awarding a prize for the best table clinic presented by a student at the Annual Conference of the B.D.A. to be held in Cardiff in April, 1979.

Each school is asked to nominate one student to present a demonstration at the Conference. The one who is chosen to represent Guy's will be selected at the Guy's Annual Clinical meeting to be held on March 3rd, 1979.

Any student who is considering submitting a demonstration in March on either a Technique or procedure concerned with some phase of dental research, diagnosis or treatment should contact Dr. R. B. Johns for further details about entry and financial assistance.



Introducing the Gazette at this year's Freshers' Fair.

Orchard Lisle Swimming Pool Winter Session Hours of Opening

Commencing on Monday, October 23rd, the Swimming Pool will alter its hours to those usually adopted during the winter months.

From that date the pool will be open during the following hours:

MONDAY:	*08.00 - 17.30 hours*	*(Club session 18.00 - 19.30 hours)*
TUESDAY:	,, ,,	,, ,,
WEDNESDAY:	,, ,,	,, ,,
THURSDAY:	,, ,,	,, ,,
FRIDAY:	*08.00 - 19.30 hours.*	
SATURDAY:	*08.00 - 14.30 hours.*	
SUNDAY:	*CLOSED.*	

Monday to Thursday inclusive, the last ticket will be sold at 17.30 hours and swimmers will be asked to be out of the water by 17.45 hours so that the Club Session may commence promptly at 18.00 hours.

On Friday, there will be no Club Session and the last ticket will be sold at 19.30 hours. Swimmers will be asked to be out of the water by 19.45 hours.

On Saturday the last ticket will be sold at 14.30 hours and swimmers

will be asked to be out of the water by 14.45 hours.

On Sunday the pool is closed.

If you have any queries regarding the information contained in this circular, please contact Mrs. H. D. Hiam, Administrative Assistant—Hotel and Support Services on extension 2664.

Dates from the Medical Diary

Monday, 13th November
Examinations for the M.B., B.S. (Revised Regulations) Part IV may begin this week.

Monday, 20th November
Entries close for Final Conjoint Examinations in December.

Monday, 27th November
Examinations for M.B., B.S. (Revised Regulations) Parts V, VI, VII and VIII begin.

Monday, 4th December
Examinations for M.B., B.Chir. (Cambridge) begin.

Clinical Day Programme — March 3rd, 1979

A prize of ONE TICKET to the Annual Dinner and Ball which is being held on March 3rd at the Grosvenor House Hotel, is being offered by the Management Committee of the Dental Society for the most appropriate design of a front cover for the Clinical Day programme.

The conditions and format are as follows :—

1. The prize is only open to Undergraduate Dental Students at Guy's Hospital Dental School.
2. The design must be submitted to Miss Anne Webster of the Dean's Office by Monday, 27th November.
3. The programme is printed by the litho offset process and the colours which may be used are limited to a maximum of two of those on display on the Notice Board on Floor 24.
4. The wording to appear must be "Guy's Hospital Dental School Clinical Day 3rd March 1979".
5. The size of the programme will be 21 cm. x 14.5 cm. (approximately the size of the *Gazette*). If appropriate to the design, the outside back cover may also be incorporated, i.e. 21 cm. x 29 cm.
6. The Judges for the competition will be Mr. M. L. Maberley and Dr. R. B. Johns, from whom any further details may be obtained.

NOTICE

Hospital Full Blues

The annual meeting for all Hospital Full Blues will be held on Wednesday, November 8th at 5.0 p.m. in the Committee Room, Boland House. The purpose of the meeting is to elect a new Blues Committee for the coming year. The newly elected Committee will go on to consider awards for the Summer Season 1978. Would the Captains of the Summer sports kindly send their nominations for Full and Half Blues to the Secretary as soon as possible.

M. C. E. HUTCHINSON, Hon. Sec., Blues Committee.

Dental Society Programme

Any student wishing to take dinner with the speakers should contact Adrian Pini.

Tuesday, 12th December
Sexual Fulfilment—A Bridge Too Far?
Mr. Maurice Yaffé.

Tuesday, 9th January
How Special? Dental Care for the Handicapped.
Diane Plamping and Martin Hayden.

Tuesday, 23rd January
From Dizzy and Delightful to Death's Door.
Dr. Marsha Morgan.

Tuesday, 6th February
Sailing Round the World.
Mr. Robert Jackson.

Tuesday, 20th February
May I Make a Suggestion?
Mr. Martin S. Brookes.

Saturday, 3rd March
Annual Clinical Meeting.
Dinner and Ball, Grosvenor House Hotel, Park Lane.

Tuesday, 13th March
Nautical Dentistry.
Surgeon Rear Admiral (D) W. I. N. Forrest.

Tuesday, 3rd April
Shall We Go and Practise in Europe?
Mr. R. B. Allen.

Tuesday, 24th April
Dental Practice Forum

Tuesday, 8th May
Annual General Meeting.

Lectures from the London Medical Group

A series of lectures arising from the study of issues raised by the practice of medicine will be held at the following venues:—

Tuesday, 7th November (Symposium), St. Mary's Hospital Medical School, 5.45 p.m.
Attempted Suicide: Does acute admission solve the problem?

Thursday, 9th November (Symposium), St. Thomas's Hospital, 5.45 p.m.
Legalisation of Cannabis: The consequences.

Tuesday, 14th November (Illustrated Lecture), U.C.H. Medical School, 5.45 p.m.
The Nature and Management of Terminal Pain.

Thursday, 16th November (Symposium), Westminster Medical School, 6.15 p.m.
Depression: A result of Inner City life?

Tuesday, 21st November (Lecture), Charing Cross Hospital, Fulham, 6 p.m.
Mental Breakdown in the light of changing attitudes.

Thursday, 23rd November (Symposium), Guy's Hospital Medical School, 5.45 p.m.

WELCOME TO GUY'S

MESSAGE FROM THE DEAN

The choice of career and where to study for it are among the major decisions in anyone's life, yet I suspect that for many people the processes of thought which lead to these decisions are as insubstantial and illogical as those which subsequently lead them into matrimony. This does not mean they make the wrong choices, or that those who appear to know exactly where they are going and why are necessarily more likely to succeed. "Why do you want to be a doctor?" is of course the stock question of the interviewer for medical school places; but he is likely to be more interested in how the question is tackled than in the actual reasons given. Lacking any family background in medicine and having done no science at all, I was within a fortnight of leaving school when it suddenly came to me that I would like to be a doctor; and when apprised of this fact my Headmaster, instead of blowing his top at this belated change of plans, simply said "if you're going to be a doctor you'd better go to Guy's". That's why I'm here. Many of you, no doubt, could give much better reasons for being here. Very few, I venture to suggest, will not look back on their arrival here as one of the happiest events in their lives and it is with unusual confidence in the accuracy of this prognosis that I bid you all welcome as members of the Guy's family.

J. C. Houston.

FROM THE DEAN OF DENTAL STUDIES

As undergraduate students you will find that you have much greater freedom to plan your own pattern of study and leisure activities than you had at School. Guy's has a great deal to offer with a large variety of scientific societies and sports and recreational clubs, but these are only as good as their members make them. It is up to you to ensure, by enthusiastic involvement, that the organisations you support are worthwhile.

As dental students you are all members of Guy's Dental Society. The programme of fortnightly lectures may have a mainly clinical flavour but pre-clinical students are encouraged to attend these meetings. To begin with the terminology of clinical dentistry will be foreign and largely unintelligible but the contact with students in more senior years and an appreciation of the magnificent facilities of the lecture theatre, and indeed of the whole of the Dental School in Guy's Tower, should whet your appetite for what is to come.

The undergraduate period should be the happiest time of your life, but should not be entirely carefree, for as dental students you soon will have the responsibility of caring for patients. This is a privilege and their welfare must be given priority. It may be wise to reflect that during the whole of your future professional career the main criterion on which you will be judged is your ability to gain and maintain the respect and trust of your patients. Thus habits and attitudes developed during these formative years are of the greatest importance. A student who frequently is late, or fails to appear for appointments with patients is not only giving Guy's a bad name and providing immediate problems for his colleagues and the staff, but is likely, if he does eventually qualify, to prove a disorganised and inefficient dentist.

Finally you should remember that the teaching staff are here to help you at all stages of your course. They are keen to answer your questions, attempt to solve your problems and discuss your ideas. Therefore, you should always feel able to approach your teachers; it is only in this way that the splendid staff-student relationships which have long been a feature of the Guy's tradition will be maintained.

I welcome you to Guy's and wish you well.

R. D. Emslie.

FROM PROFESSOR WARWICK — ON LEARNING

A few years ago a *Gazette* editor set the style of the October issue by inveigling "welcoming" remarks from a few senior members of the teaching staff and the habit persists. It is, of course, rather too late to say "Welcome", but you certainly are! I have already met more than a few of the fresh entry of students, and some are beginning to know me too! What strikes me most pleasingly is how much I am already *learning* from *you*; and that is also most reassuring, for the longer I live as a teacher the surer I am that it is *learning* which really counts—a lesson which I have been inordinately long in *learning* for myself. Though I must have known in schoolboy years that e-duc-ation is a cousin word to *dux* (ducis), a leader, it has dawned upon me with unconscionable tardiness that education is literally a *"leading forth"*—an encouragement to wider vistas—not the dictation to an inert audience of what to do and think or, much worse, what not to do.

"To learn is a natural pleasure, not confined to philosophers but common to all", according to Aristotle, and that is also my belief. But, said Plato, "Trees and fields tell me nothing; *men* are my teachers", a somewhat narrow view, but perhaps even Plato was ready to *learn,* not only from his teachers' lecturing and conversation, but also from wider sources by his own efforts. I prefer Aristotle's outlook, or the words of Tze-Sze: "To be fond of learning is to be near to knowledge". So why not enjoy it? We all know, inevitably, why you are here, though the motives may be as various as undoubtedly are the uses of a medical education. But "the function of a university is not simply to teach bread-winning", as Du Bois opined, "it is . . . the fine adjustment between real life and the growing knowledge of life . . . which forms the secret of our civilization".

Remember that you *are* in a university, with all the privileges, and the disadvantages. The weaknesses of the system have attracted innumerable criticisms from the "distinguished" and anonymous among its products, and even more abuse from those who seek to console themselves on having "escaped" from it. But the university system outlives them all. We all know that it is often cumbrous, sometimes crude and inept; but universities still comprise the largest communities of people interested in *learning* and not just in teaching. They differ primarily from schools in that the teachers are expected by their research to go on *learning.* Not all do, and you will doubtless *learn* to discriminate. But take your cue from those who do, and you will *learn* with Oliver Wendell Holmes that "the main part of intellectual education is not the acquisition of facts but learning how to make facts live".

Most of your teachers here are daily engaged in the lively business of extending the facts, the *learning* which they hope to pass on to you. For them the facts truly live under the travelling searchlight of their own research, in the endless refinement and extension of *learning* which is the special talent of mankind. How can they therefore not respond to any clear desire in you to *learn*, and not just to be inertly taught. There *is* a subtle difference. However good or bad your teachers are at teaching (which is merely technique, however enviable when good), all those who are still themselves *learning* can help to educate you, in the noblest sense of the word, even if *you* must drag it out of them. And you *must* take an active part in the process of transference of knowledge and understanding, for it is an effort in partnership and the heart of the university system. Otherwise you may, like Emerson, "come out at last with a bellyful of words and do not know a thing". (Presumably Emerson was a rather inert scholar.) Use your teachers, clamour around them, encourage them (if they need it) to encourage, to educate you. Together, progress is certain. Perhaps I should not commit others to this view; but I speak for myself when I say, "Use me to the full capacity of your determination and desire to learn. I am a teacher, it is my life, and I like it as much as, I hope, you will find pleasure and profit in *learning*".

Roger Warwick.

THE PHYSIOLOGY DEPARTMENT

The academic staff of the Physiology Department consists of nine full time and two part-time members. They are involved in teaching BMS, 2nd BDS, honours B.Sc., and postgraduate students. The main aims of the teaching course are to present the fundamental facts of physiology, and to get the students to interpret physiological data.

Most of the teaching takes place in relatively small groups of approximately fourteen students and lectures are given on the essential or conceptually difficult aspects of the course. Following the preclinical courses there is an opportunity for a few students to study for an houours B.Sc. The B.Sc. projects are related to the current research interests of the members of the department.

Whilst a considerable amount of the academic staff's time is taken in teaching physiology, each member of staff pursues his own research interests. These include such areas as dietary carbohydrate and lipid metabolism, ventilation, and cutaneous, oral and visual physiology. Although for purely research purposes a department devoted to one topic has much to commend it, a diversity of interests is an advantage when teaching physiology as the special experience in several fields can be valuable in the discussion of controversial topics.

Ian Macdonald

THE DEPARTMENT OF BIOCHEMISTRY AND CHEMISTRY

This is the first time that I have been asked, as Head of the Department to write a few lines for the "*Gazette*" to welcome new students to Guy's, because, like them, I have only been here a short time. Some of you have come as Preliminary students and will be studying basic chemistry before going on next year to biochemistry in either the dental or medical

courses; chemistry is the first essential stage in the understanding of the biochemical basis of disease so a good grounding in the subject is essential to the modern doctor or dentist. The biochemistry course for dental students is organised by Dr. D. B. Gower, Reader in the Department; it is only quite recently that the importance of biochemistry for dental students has been recognised, and much effort has been put into designing a course which fulfils this need. The aim is to present biochemistry as a subject which has the potential for explaining many of the phenomena which are puzzling to the dental practitioner and with which he will be engaged for a large part of his professional life.

My particular concern since I came to Guy's a year ago has been with the B.M.S. course in biochemistry. My predecessor, Professor G. A. D. Haslewood, began a re-organisation of the course shortly before he retired, and I am building upon his modifications. A little thought will convince anyone concerned with human disease that the ultimate cause of every disorder must lie in a disturbance in the chemistry of living cells. Understanding of normal biochemistry is therefore of primary importance to medical students whose professional lives will eventually be largely concerned with the end product of something going wrong with their patient's biochemistry. Our primary objective has thus been to design a course which gives a good grounding in the basics without losing sight of the relevance of basic biochemistry to medicine and then, in the second part, looks outwards more particularly to what we know about the application of biochemistry in the understanding of certain disease states. The practical course has also been re-designed in collaboration with the Head of the Clinical Chemistry Department, and it is intended both to illustrate basic facts of biochemistry and to give experience which will be of relevance to the clinical chemistry course in later years of the curriculum.

Although a great deal of the time of the staff in the Department is taken up with teaching, a number of different research projects are under way. Among the problems currently being investigated are the cellular action of vitamin E, the biochemistry of heavy metal toxicity, some aspects of the biosynthesis and mode of action of steroid hormones, the biochemistry of hereditary muscular dystrophy, investigation of chromatin proteins, regulation of membrane associated enzymes and investigations on the biochemistry of myelin.

Anthony Diplock.

B.M.S. PSYCHOLOGY AS APPLIED TO MEDICINE

Psychology is taught in the last two terms of the B.M.S. course and both the timing and content of the course offer something of a bridge between the pre-clinical and clinical courses. There are strong links with other pre-clinical disciplines such as neurophysiology and neuroanatomy in dealing with the relations between brain mechanisms and behaviour. At the same time much of the course has a direct reference to clinical medicine since there is a consideration of such topics as doctor-patient interaction, hospitalisation, handicap and the nature of psychosocial stress factors in illness. Psychology also makes a significant contribution to the B.M.S. Human Reproduction and Clinical courses.

As a relatively short course there is not such a strong emphasis on the acquisition of a large body of facts but an attempt to convey general prin-

ciples of individual human behaviour, particularly where these will be of relevance to clinical practice. The overall objective is to broaden the students' understanding by engendering an awareness of the importance of psychological factors in the aetiology and treatment of clinical problems.

The Unit of Psychology has active research interests in clinical and experimental areas and offers a number of places each year to students wishing to take an intercalated B.Sc.

John Weinman.

UNIT OF SOCIOLOGY AS APPLIED TO MEDICINE

Medical Sociology is taught to three groups of Guy's students:

(a) A 40 hour course is given to the preclinical students in their 6th B.M.S. term. The emphasis of the course is on the various social factors which effect how people come to use health services and how they respond to treatment. This includes social factors in the aetiology or organic and psychiatric disease and in the delivery of health care.

(b) Dental students receive a short course in their first clinical year on the relationship between social factors and attitudes and behaviour towards dental care as well as the problem of assessing and providing for dental need.

(c) A variety of course units in medical sociology are offered on an inter-collegiate basis to those students satisfactorily completing their B.M.S. course.

David Armstrong.

A Christmas Gift from Guy's!

Sets of the three Hanslip Fletcher etchings of Guy's Hospital are available showing the Main Entrance, The Park and Hunts House. They make fine Christmas gifts.

Set of three £1.50 (including postage and packing)

Prepaid orders to the Manager, Guy's Gazette, 16 St. Thomas Street, SE1 9RT.

Personal callers welcome.

THE DEPARTMENT OF PHARMACOLOGY

This introduction of the teaching of pharmacology at Guy's provides a good opportunity to welcome new students to the Medical and Dental Schools. The pharmacologists and clinical pharmacologists are fortunate in coming in contact with the students from their first days and continuing the association until the final examinations. Even beyond this practising doctors and dentists have come to realise the awful truth about modern drugs—which is that many of them are highly potent modifiers of cell function. This means that they can influence disease states but may also produce serious toxic effects.

Perhaps one of the most important aims of the pharmacology and therapeutics courses at Guy's is to correlate the molecular aspects of drug action with clinical importance of this in medical practice. Because the term drug includes any chemical which can alter cell function, the range of substances which practitioners currently use is astonishing. Similarly the implications to man of the effects of a single drug are sometimes remarkably broad. Alcohol, for example, has not only been used in treatment (to dilate arteries) and prevention of disease (by sterilising the skin) but the many diseases caused by alcohol may have medical, surgical, paediatric, psychiatric, genetic and sociological aspects.

Perhaps the neatest way of summing up is by defining pharmacology as how small molecules do big things.

Roy Spector.

THE DEPARTMENT OF PATHOLOGY

It is 21 years exactly since I started as a medical student at Guy's, and it did not occur to me at that stage that I should become a Consultant Pathologist at Guy's. Medicine has such enormous breadth, ranging from psycho-geriatrics to paediatric surgery, and from clinical genetics to forensic pathology that it can accommodate a very wide range of talents and interests. The seductive nature of dynamic clinical subjects like surgery and clinical nephrology are obvious. The rewards of a career in Pathology are not the drama of surgery nor the financial benefits of private practice, but the steady glow of pleasure which comes from building a body of knowledge within one's subject that becomes even more fascinating as the years go by. It is difficult to pass on such feelings to others, with little or no experience of the subject, and I regret that most pathologists fail to impart this feeling of pleasure to the students they teach. I would suggest that when you come to study pathology, try the simple experiment of involving yourself deeply in some small aspect of the subject which is relevant to a patient you have seen. You should find that this is both an interesting and rewarding experience. Ideally you should then seek out someone who is knowledgeable in that particular subject to discuss any points of uncertainty or difficulty. By this time you will be on the brink of beginning to understand the fascination of pathology. Indeed I have found that the time and energy which I have put into my studies has proved to be the best investment of my life. Surer by far than guilt edged securities or investment bonds.

David R. Turner.

THE QUESTIONS YOU ASK US

Jean Farmer
Wills Librarian, Guy's Hospital Medical and Dental Schools

How do I find a book in the library?

The card catalogue, opposite the issue desk, is arranged in author and subject sequences. On the top right-hand corner of each card are letters which tell you where books are located: eg REF—Reference, SLC—Short Loan Collection, BME—the section on Anatomy, V—the section on Surgery.

What are "Short Loan" books;

These are the books in greatest demand, mostly current textbooks. They can be borrowed overnight or from Friday to Monday.

How can I find the most up-to-date book the library has on the subject in which I am interested?

The subject catalogue is arranged in alphabetical order of subjects with the most recent books on each subject first.

How many books can I have out at once?

As many as you like within reason.

Do I have to have my reader's ticket to borrow books?

Yes. Also, since you are responsible for all books issued on your reader's ticket, if you lose it please tell the library staff so that a check can be made.

How long can I keep a book out?

Four weeks, except for Short Loan books. If another reader wants your book, however, you must return it after a week.

Can I renew a book I have without coming to the library?

Short Loan books must be brought back the next day, and will be renewed only if there is another copy available. Otherwise, provided that another reader does not want it, a book may be renewed by telephone.

(Wills Library extension 3374; Dental Library extension 2805.)

Can I pass on a book I have from the library to a friend?

No, because you are responsible for a book as long as it is out on your ticket.

What should I do with my book when I bring it back?

Hand it to the library staff member at the issue desk. Don't just leave it on the desk or on the book trolley nearby.

The book I want is on loan to someone else. Can I reserve it?

Yes, ask at the issue desk; you will be sent a card when the book is ready for you.

Can I obtain a book which is not in the library?

Yes, most books not in the library can be borrowed for you, generally from the British Library. These "interlibrary loans" are free to undergraduates if their tutor countersigns the request form.

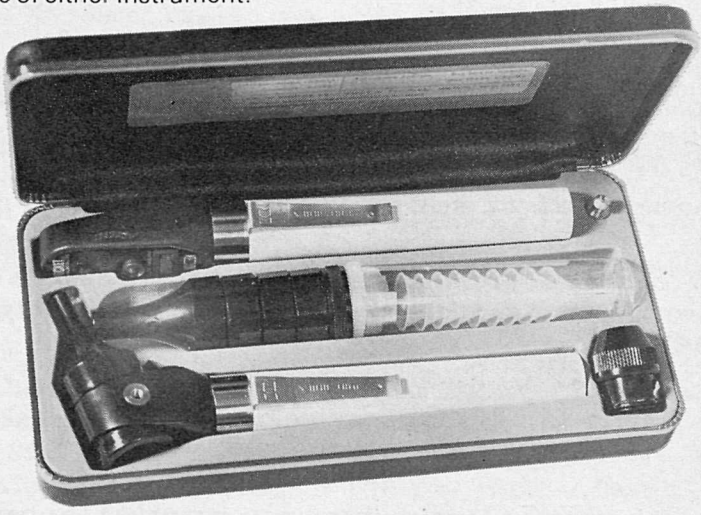
I want to photocopy my notes. Can I do that in the library?

There is a photocopier in the corridor outside the library. To operate it you need a key counter, which you may obtain from the issue desk. The cost of photocopies is 4p a sheet.

Keeler Pocket Diagnostic Set ....your first choice

Making the Keeler Pocket Diagnostic Set your first choice will give you the diagnostic capability needed for your student years and beyond. The smallest, lowest priced diagnostic set in the Keeler range is also one of the most comprehensive, with an ophthalmoscope, an otoscope with permanent and disposable specula, and a pocket torch head to fit the battery handle of either instrument.

Designed to complement the larger instruments in the Keeler diagnostic range, the compact Pocket Set is already the first choice of General Practitioners and Doctors looking for a comprehensive, lightweight diagnostic set to carry with them on ward rounds and domiciliary visits.



Call our sales department on 01-935 8512 for details of special prices for students and hospital staff. Orders despatched post free immediately on receipt of payment.

Special exhibitions arranged for groups on request, or demonstrations for you to define your diagnostic instrument requirements.

Keeler

Keeler Instruments Ltd
21-27 Marylebone Lane London W1M 6DS Tel: 01-935 8512
10-12 Nile Street South Shields Tyne & Wear. Tel: 0632 569466

I am revising for exams and would like to see some past papers. Are these available in the library?

Past exam papers are held in the library and in the Medical School Office, for reference only.

The library is very crowded. Is there anywhere else I can go to study?

There are study places on the ground floor of the Gordon Museum, which is open from 9 a.m.—5 p.m., Monday to Friday.

I think that the periodical I want is in the Anatomy Department library. Can you confirm this and may I go and read it there?

Periodicals held in departmental libraries in the School and Hospital are recorded in the periodicals holdings list in the library. Departmental libraries may be used for reference, but please ask permission from the Head of Department.

I have heard about the new computerised information retrieval services in medicine. Are these available at Guy's?

Yes; ask the library staff for more information. Demonstrations can be arranged for groups of students.

Can I borrow books from the University of London library?

Yes, all students may use the University library at the Senate House. Application to join should be made at the registration desk in the entrance hall on the 4th floor of the Senate House. (Proof of student registration is required.) Ask the library staff for more details.

Can I arrange to use the university library in my home town during the vacation?

Yes, ask the library staff for a Vacation Reading Card.

If you have other questions, please ask the library staff—they are there to help you.

NOTICE

GUY'S HOSPITAL GILBERT AND SULLIVAN SOCIETY

presents

"SALAD DAYS"

by Dorothy Reynolds and Julian Slade

Music by Julian Slade

in the

Greenwood Theatre, Guy's Hospital

on

Wednesday 13th, Thursday 14th and Friday 15th December, 1978

at 7:30 p.m.

Tickets on sale in Colonnade and at the door – – – Price: 75p

GUY'S HOSPITAL RUGBY FOOTBALL CLUB

Now that the initial alcoholic haze of the first two weeks at Guy's has begun to fade, it is time to begin a gradual return to fitness. (If you recall, this is something you once had at school before "A" levels and long summer vacations.)

What better way to achieve this splendid ambition than by playing Rugby for Guy's. As well as the benefits of fitness and the pleasures of playing, you will also be maintaining a tradition at Guy's that stretches back more than 100 years. However, I leave it to Mr. T. Lewis to describe the Club's history.

The Club is running four teams this year; the captains are listed below:—

First XV: Gareth Parry.

Second XV: Simon Moore.

Third XV: Richard Dunn.

Fourth XV: Paul Silvester.

Matches are played on Saturdays and occasionally on Wednesdays. All the teams have fairly full fixture lists and play home matches at Honor Oak Park where there are two rugby pitches. Players are selected to play on the basis of their previous performances and their appearance at training sessions. These are held every Monday and Wednesday at 6.00 p.m. at H.O.P. and are coached by Martin Danford (not Banford as the press seems to think).

The Club also participates in various Sevens competitions during the year including the United Hospitals Sevens, which we won last year, and the Middlesex Sevens in the Spring. I don't want to give the impression that Rugby at Guy's is all hard games and training sessions. There are many social events organised by the Rugby Club throughout the year (apart from the regular post-match festivities). Coming events include a fireworks display and disco on Saturday, November 1st and hopefully a sponsored mixed rugby match at Christmas in aid of the Easter tour which this year is to Eire. There is also a Past v. Present weekend during February, at which time past First XV players are rounded up from the four corners of the country to do battle with the present First XV.

Finally if you are interested in playing Rugby, please contact any of the team captains who will be delighted to hear from you. Remember that the continuance of Rugby at Guy's depends on your support.

For fixture list see page 452.

Jon Beard.

Guy's Rugby Club First and Second XV's 1978

Top L to R: T. Wilkinson; J. Smith; S. Bukofzcer; T. Palmer; C. Howell; I. Neill; P. Loxton; B. Keevil; C. Jackson; G. Manning; C. Tunnadine.

Middle L to R: C. Robertson; P. Davenport; G. Francis; G. Parry; J. Beard; M. Broughton; T. Mart; A. Portelly; M. Danford; B. Hagan.

Bottom L to R: R. Laws; A. Harris; P. Birtles; T. Gibson; R. Flannegan; H. Williams; R. Cording.

A HISTORY OF GUY'S HOSPITAL RUGBY FOOTBALL CLUB

T. L. T. Lewis

First published in the Guy's Hospital Gazette in 1968, this history is reprinted for the benefit of new students, and to refresh again the memories of the old !

Foundation in 1843

The evidence for the foundation of the Club in 1843 is somewhat circumstantial, but the claim has never been seriously challenged and it places Guy's in the position of being the oldest Rugby Football Club in existence. Both Sir Frederick Taylor and Mr. J. N. C. Davies-Colley, who entered Guy's in 1863 and 1865 respectively, told Dr. Alfred Allport that 1843 was the date accepted by all as the year in which the Rugby Club became established. This was repeated to Dr. Allport by Mr. E. B. Turner who played for St. George's Hospital and England in 1874. In the words of Dr. Allport, "This may be taken as substantial confirmation amounting to certainty, for men's memories carry back thirty years with accuracy and if the 1843 date was admitted in 1874 by other hospitals, it may be accepted as the correct

one". A fixture card produced by the captain of the team for the year 1883-4, Dr. R. H. M. Randell, referred to the fact that it was the club's fortieth season, "indisputable proof that the Guy's Hospital R.F.C. was formed and played its first matches in the season 1843-4", according to an article in *The Referee* of October 2nd, 1921 J. B. G. Thomas, in "Great Rugger Clubs" (Stanley Paul, 1962) wrote: "It is the pride and joy of all members, past and present, of the Guy's R.F.C. that theirs is the oldest in the game's history. Of this there is no doubt, despite the claims of other less distinguished bodies to the worthy title".

Early Days

What do we know about the game in those early days a century or so ago? At first, Guy's played on the Common at Blackheath, sharing a dressing-room in the billiards room of the "Princess of Wales" Hotel with the Blackheath Club after their formation in 1862 from the Old Blackheathens, old boys of the Blackheath Preparatory School. A club attendant who lived at Blackheath rose "with the sun" on the morning of a match and, taking the posts with him, staked out the Guy's claim on the heath. The field of play was generally fairly clear of stones and broken bottles, but not always. There would be other matches going on a few yards away and Dr. Allport described an occasion when the full-back allowed an easy try because he was busy cheering a run by a player on a neighbouring pitch. Distraction was also caused by people out for a walk with the dog who would wander across the playing field. Until 1877 sides, including the International ones, consisted of twenty players each if that number were available. The code of rules to be played under was decided at the time by the two captains, and this led to many arguments. Two rules were usually agreed upon; that no player might be held and hacked at the same time, and though a player might be held in the scrummage, no attempt must be made to throttle or strangle him. Hacking, or kicking the shins of an opponent to keep him away from the ball, was one of the main issues for debate until the practice was banned by the Rugby Union on its formation in 1871. The method of scoring varied from time to time until 1893. Before then a match was won or lost only by goals (successful kicks between the posts after a try); in the event of an equal number of goals, or no goals, tries were counted; if the number of tries was also equal, rouges or touch-downs were counted. From the very earliest days the membership of the Guy's R.F.C. was closed. Only students and qualified members of the hospital were entitled to join.

Formation of U.H.R.F.C.

The United Hospitals R.F.C. was formed in 1867 and the Hospitals Cup competition inaugurated in 1874. It was in this competition that a system of scoring points was first used, three rouges equalling one try and three tries equalling one goal. In 1871 "a party of thirty-two members of London and Suburban Football Clubs following the Rugby School laws, assembled in solemn conclave at the Pall Mall Restaurant in Regent Street, London, under the presidency of E. C. Holmes, Captain of the Richmond Club, and resolved unanimously that the formation of a Rugby Football Society was desirable, and thereupon proceeded with all due deliberation, to found the Rugby Football Union" (Arthur Guillemard in "Marshall's Football", 1892). Guy's Hospital was not only represented at this meeting but one of its members, J. H. Ewart, was elected to the first committee.

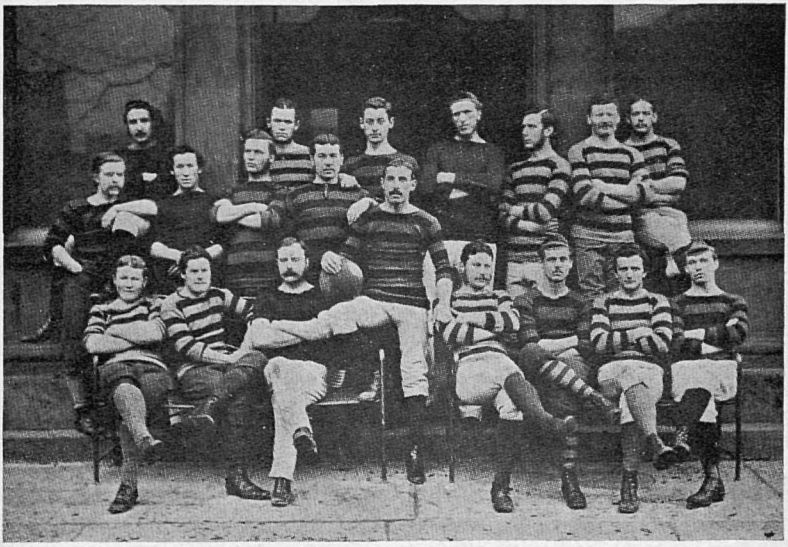
1860s and First Cup Final

Dr. A. Allport tells us something about the men who played for Guy's in the nineteenth century, beginning with Sir Frederick Taylor who, in 1863, "was a fast and clever three-quarter" and Charles Higgins who "joined in 1864, played half-back and was ready for a scrap with anyone. Standing not more than 5 feet 2 inches and weighing under 9 stone, he was a compact little mass of agility and determination. The year he was reaching the age limit of sixty and retiring from the position of Oculist to Guy's, he gave an exhibition three rounds of boxing with Jem Brock, the celebrated lightweight champion who was one of the last to fight with bare knuckles. It was a wonderful example of hard hitting and good condition against a seasoned pugilist ten or fifteen years his junior". In the year 1873, W. W. (Nipper) Pinchin, known as Conchy Bill because of his long nose, was elected captain for the fourth year in succession. He played for England in the first International against Scotland at the Oval, Kennington, in 1872. Subsequently he became ship's doctor on a passenger liner, but was washed overboard in a gale and was never seen again. A challenge from St. Bartholomew's Hospital was declined because "the last match three years previously was attended with much unpleasantness—ending, in fact, in a free fight, with Charles Higgins very busy on this occasion and doing himself ample justice in the fighting!" Playing with Pinching was another England International, A. W. Pearson, "about as fine a full-back as ever played; beautiful drop and place kick and a dead sure tackle. He never did any work at Guy's and only entered to play in the cup ties. He went to Australia in the eighties to farm". Guy's had a very strong team, six men appearing in the All-England trial games. They were surprisingly beaten by Blackheath due to "a nasty trick adopted by the Blackheath forwards, of heeling the ball out of the scrimmage". However, they won the first Hospital cup competition on March 3rd, 1875, beating St. George's in the final by one goal and one touch-down to two touch-downs. The *Gazette* reported, "The fierce struggle, the running, the kicking, the intense excitement and cheering of the spectators form a picture that we shall recall when we are old—old in years; but which will make our pulse beat again with the freshness of youth, while the players in the Guy's team, like the old victors at Agincourt, will raise their heads with pride at every anniversary of March 3rd, 1875". (Cup fever 103 years ago!).

1870s

We lost the Cup in 1876 but regained it in 1877. On that occasion we had playing for us Leonard Stokes, who was to play for England twelve times, on five occasions as captain. In the *Gazette* of 1893 it said, "He was a faultless catch and field, and a very quick starter, and with his speed of foot, wonderful dodging powers, and clever 'shoving off' was an extremely difficult man to tackle. An excellent place-kick, he was also for several seasons the longest drop in the three kingdoms. Some of his drops at goal from difficult positions, when hemmed in by opponents, were simply marvellous. His tackling was not quite up to the standard of the rest of his play, as he frequently aimed too high, but his great speed often enabled him to rectify an error by a second attempt". So he was human after all. When he left Guy's he became captain of Blackheath, scoring fifty-six tries out of one hundred and thirty-six by the whole team in eighty-three matches. In his fifth match as captain of England, he managed to force Scotland to

a draw by an extraordinarily fine kick. "Catching the ball from a kick-out he obtained a goal by one of the grandest drop-kicks ever seen, the ball travelling fully eighty yards from kick to pitch" (A. Bull, "Football"). At half-back for Guy's, were two more Internationals, A. H. Jackson, who was powerful and clever, "a good drop with either foot and absoluitely chock full of pluck and resource" and his partner, the captain, W. G. Gray. The latter found Jackson to be very selfish. He could only remember Jackson passing the ball to him on one occasion, when he dropped a goal. "Damn", said Jackson, "I could have done that myself". In the cup match against St. Thomas's, Gray wore a jersey without sleeves and put "a modicum of oil" on his bare arms to make it difficult for his opponents to catch hold of him. Unfortunately he dislocated his shoulder early in the second half. He retired to the pavilion, but when three members of the Guy's staff failed to reduce it he returned to the field and played full-back. Later "under chloroform the reduction was quickly accomplished but the triumphant ride back to the hospital, in a 'growler' with the coveted Cup, was marred to some extent through the vomiting induced by the anaesthetic".



The Guy's Hospital R.F.C. Twenty, Season 1873-74.

J. F. Breach. P. E. Wallis. H. Duke. G. E. Power. H. Hetley.
C. L. Mutch. P. F. Gilbert. T. Brown. J. Boughton. H. Welchman.
F. Wells. W. W. Pinching (Capt.). W. G. Gray. A. Finch.
E. S. Robson. J. Rendall, R. C. Gibb. H. A. Collins. F. B. Maclean.
Absent: A. W. Pearson.

Following the outstanding season of 1876-7 "the team being one of the finest the hospital has ever turned out, with the pick of the English Twenty behind the scrimmage", it was not surprising that the results were not so good. The finances of the Club were in a bad way and there was difficulty in obtaining a full team through several of our best men playing for out-

side clubs, a perennial problem it seems. In the early 1880s A. S. Taylor was playing full-back for Guy's. "He was a sure fielder and kicked and tackled very low; he would gather himself together and shoot at his man like a streak of lightning, bringing him down all of a heap". He played for England on four occasions. Albert Martin, an Australian, was "a powerful bullocking three-quarter with a fair turn of speed" and R. M. H. Randell, captain in 1883-4 was "a big powerful forward of the very robust type, whose shoving in the scrimmage was only equalled by the keenness he shoved into his team". "Trojan" Marriott, brother of the man who was Rugby Union Secretary for so many years, was able in 1885 to "imbue his men with the keenness which culminated in their winning the Cup after an interval of seven years". H. M. Jordan, a brilliant and dashing three-quarter with a fine swerve, played for Wales three times and was immensely popular with the crowd. Unfortunately he played mostly for Blackheath. It is said that in an effort to prevent Jordan getting through their line in a Cup match in 1884, the London Hospital played four three-quarters instead of the usual three. This tactic was adopted in Wales and soon spread generally. Guy's were therefore partly responsible for the modern three-quarter line.

To be continued next month.

EARLY DAYS

By Professor Keith Simpson, C.B.E.

(An excerpt from Professor Simpson's autobiography "40 Years of Murder", to be published in November by Harrap)

I became a doctor because my father was one. A very good if rather old-fashioned G.P., he had a vast following of devoted patients to whom he was both general adviser and doctor, and he would have been intensely disappointed if one of his sons had not followed him into medicine. Denis, my elder brother, disliked all forms of study, so it was as well that no career other than medicine ever crossed my mind. My mother, a calm talented woman, who spoke and wrote well, wisely refrained from putting other ideas into my head.

My father came of Scots parentage but his family moved south while he was still a medical student, so that he qualified from Edinburgh and then University College Hospital in London. He bought a practice, as one did then, in Brighton and Hove, where I was born. It was a flagging practice, but he built it by his industry and deep concern for his patients' welfare into a "four-man practice" of which, when I was at school and later at Guy's, he was senior partner. He was a splendid representative of the older G.P. He seldom indeed read the *British Medical Journal* or *Lancet*, but he knew when a patient was ill—there were few specific treatments then—and he also knew when a case was beyond his standards of care . . . when to call in a specialist like the great Lord Horder for an opinion and guidance. He was undoubtedly happiest out on his rounds driven in his favourite Buick by his deaf chauffeur Wood who, like most of his flock of patients, was devoted to

him. Brisk, fresh, alert, and always keen, "the Doctor" would nearly always be out of the car before it had drawn to a standstill and with a double knock on the door was in most homes with a "May I come in?" whilst many would still be peering about for the number of the house. In the family he was a strong disciplinarian, and I never found a way of speaking at all intimately with him, even when, late at night, he at last relaxed with a book. His work was his passion and his pleasure, and being on holiday obviously bored him after the first forty-eight hours.

School never held any terror for me. My first teacher, a Madame Gengoult, Head of a preparatory school in Preston Park, had the twin gifts of enthusiasm for her art and the ability to impart knowledge as if it were an exciting cult. She spoke her native language, French, by interjections of "du tout" and "ma foi" between her deliveries in English, and always started any more difficult subject with an affectionate "Now, mes enfants. . . ." This warm-hearted Frenchwoman inculcated in me a desire to learn which has given me the greatest pleasure ever since.

I was fortunate, too, when I went to the old-established Brighton Grammar School. The Head was the portly "T. Read, M.A." (I can still forge his signature!), a delightful fatherly scholar of English and "the Scriptures" who also taught applied maths. An occasional "Good, my boy" was earned with difficulty, but well worth the effort. I learned with pleasure, even wore "gig-lamp" brass-rimmed spectacles at one stage, and was despised as "a swot" by my brother Denis, who was firmly determined to avoid all kinds of education. He left the school at sixteen, being quietly withdrawn after making no real progress for some years, falling behind all his fellows irretrievably, to go to farm in Sussex and later, unsuccessfully, in Rhodesia. A most amiable brother, just lacking in ambition.

The lasting impression that stayed with me through my school, medical school, and university life at Guy's, was the deep tie of regard and affection that develops between teacher and pupil; they are akin to those between master and apprentice when both are devoted to acquiring the same expertise. I enjoyed the power a teacher has to impart the one thing that matters in academic life, learning, and at the same time to acquire affection. Touring India, Thailand, Hong Kong, Australia, and New Zealand years later I found a long stream of charming past pupils, students and post-graduates keen to lavish the warmest hospitality on me for no better reason than "warm regards to my teacher".

Languages attracted me as a boy, and my first taste of travel came from a French travelling scholarship I was awarded at school. I lived for a short time undergoing "tutorials" in a French country family home near Pithiviers (noted for its lark pâté) and I never found the language troublesome thereafter. Years later, on a lecture tour of France for the British Council, I had the great honour of speaking at the Sorbonne University in Paris. I had prepared this lecture with great care, in French that was given a final Roget-like polish by a French teacher in London University (for a substantial fee). A sad anti-climax ensued: on the way from dinner near Etoile with my hosts, the Anglo-French Society, driving with Monsieur Corbin, a former French Ambassador, this distinguished white-haired old gentleman leaned over towards me in the car, placed a hand on my arm and said conversationally, "By the way, Doctor, I quite forgot to mention to you. This particular audience would be much flattered if you would address them in your own

English language." Alas for my skills, and tutored veneer, in French! And my Roget polish expenses! All down the drain.

My father showed no discernment about my studies and regarded school, matriculation, and some kind of medical education and qualification as "necessary" for my future. All good Scots have to be industrious and earn a living, an honest living, and any thoughts I had about going to one of the older universities—which was easy enough then for those with the means—failed altogether to appeal to him. Learning, for its own sake, was "wasting time", and I had to accept the decision. When I went from school to medical school I was still a schoolboy of 17: the maturity that a couple of years at Oxford or Cambridge would have given me was almost painfully lacking.

In the years between the wars, medicine was still a rewarding professional career, and there was no difficulty then in finding a place in any of the university schools. London was the obvious choice, and Guy's was the nearest medical school, so, armed with a pretty good-looking matriculation certificate from my Brighton school, I presented myself one 1924 August morning, red hair brushed, and in a tidy blue suit, at Guy's.

"I wish to enrol at a medical school," I said to the clerk, a delightful Edwardian character called Croucher, black coat, striped trousers.

Now these days it's only after a strict perusal of papers by the Advisory Board, letters of outrageously extravagant recommendation and a tough interview with the Dean and a School Selection Board that you may perhaps be offered one of the one-in-twelve (one-in-seventeen if you're female) places for next year.

Not so in 1924. The School Clerk had the entire authority.

"Do you have the money for the fees?" asked Croucher courteously.

I had—and Croucher himself enrolled me on the spot.

University and state backing for the medical schools did not then exist. Guy's was a "voluntary hospital", living largely on the rich foundation with which the bookseller Thomas Guy had in 1720 endowed it, and the school depended largely on the students' fees. On the annual "rag" day the students, attired in a variety of fancy dress—I had a tough bright-spotted orange and blue (Guy's colours) harlequin outfit—poured out on to the London streets, boarding taxis and buses, pestering the good old English businessman around London Bridge for contributions for the Hospital. "Something for Guy's, guv'nor . . . ma'am. Go on, sir, you might find yourself in there tomorrow.' And several thousand pounds would come in to support the tottering structure of the Voluntary Hospital System.

Guy's then had several remarkable teachers, headed by T. B. Johnson, our Dean, a strict Scots disciplinarian Professor of Anatomy who at that time edited the famous *Gray's Anatomy*. And when we moved over to "walk the wards" we found a new breed of man—the physician, the West End Consultant who, if he was worth his salt, came down twice weekly to Guy's in his Rolls to do a voluntary afternoon round. This was indeed an occasion. The Registrar, his House Physician and the "firm" of students, perhaps eight or ten of us, would assemble in white coats at the Front Lodge where, punctually at 2 p.m., the great man would arrive. My idol at the time was Dr. Herbert French; tall, handsome, successful, he was always immaculately dressed in grey Ascot tails and topper. He would bound up the front steps

from his Rolls, leaving his grey liveried footman to collect his letters at the Lodge as "Lofty", the top-hatted Head Porter, saluted him "in", and was striding out down the famous Colonnade, where the great Bright and Addison and Hodgkin had trod before him, and into the Park before most of his "firm" of students had got into gear to stream after him.

Another of my heroes was Dr. E. R. Boland, then Clinical Tutor and later, as Sir Rowan, Dean of the Faculty in the university. He had been sadly knocked about in the First World War but was incisive, slim, clean, fresh-faced, wore a black monocle to conceal an eye wound and was always well dressed. He taught generations of Guy's men the courtesies of doctoring. It was "Bo" who as Dean of the School backed my inclinations for pathology, and a Gold Medal in Bacteriology, a "Gull Exhibition" in Pathology and a Demonstratorship which enabled me to start teaching in the subject helped me to justify his support.

I had been increasingly drawn towards teaching when, soon after I qualified, a sudden vacuum on the staff of the Pathology Department gave me the opening I was looking for. One day I was a struggling young casualty officer, next day a white-coated Senior Staff teacher in the Pathology Department. The doors to a career had opened miraculously wide for me at the age of twenty-five. The few prizes or awards I had had the good fortune to collect in my "finals" year had stood me in good stead when the vacancy had so suddenly arisen.

Long after, in the Old Bailey, at a murder trial, a passing success I had had at Guy's came to roost. I had been a pathologist for twenty years when one morning Counsel, seeking to cut to size a remark I had made in evidence about an "evident need to relieve the internal bleeding by operation", remarked:

"Doctor, what can you, a pathologist know about clinical surgery?"

It was a good question. Experts in court are always being warned not to exceed the strict limits of their own fields of specialization in giving opinions. Counsel must have felt he had me by the traditional short hairs. It suddenly came to me that I had an "escape" hatch.

"I hold," I said, "a gold medal in clinical surgery."

He was plainly shaken. Who could ever have anticipated such a disastrous answer from a pathologist? If only he had known that it had been awarded twenty years previously for writing knowledgeable papers and an essay in the subject, and that I had never in my life held a surgical knife in my hand! But he didn't know, and a moment's flush of chagrin at the reverse he moved away to another line of questioning.

My fundamental interest when at Guy's as a young teacher was in pathology, and this was—it still is—the only sound foundation for a crime pathologist. Until he has become familiar with the ravages and strange variants of disease, he is not ready to branch off into a study of injury, far less of criminal injury. Forensic pathology is a specialized branch of pathology, not open to the young tyro.

As the Senior Demonstrator in the Pathology Department I was doing the majority of all the post-mortems at Guy's, including those reported to the Coroner, Douglas Cowburn, at Southwark. It was my good fortune that Cowburn happened to need a pathologist to handle his own cases. In the ordinary way he would have used Bernard Spilsbury, who dominated medico-

legal practice at that time, but Cowburn disliked Spilsbury and only called on him when he was forced to—in major crime work. He had once paid Spilsbury a *single* post-mortem fee for examining conjoined twins! Spilsbury fumed. There were two bodies and he'd examined both: But Cowburn was adamant. Feeling never entirely died out, and though the incident was trivial it resulted in a certain "needle" between the men. So Cowburn asked the Superintendent of Guy's, Sir Herbert Eason, to permit me, whose services he found he was employing (presumably satisfactorily), to handle some of his cases in the public mortuary. Eason and the Professor of Pathology agreed, the latter created the new post of "Supervisor of Medico-legal Post-Mortems" for me, and I was off. It was the autumn of 1934.

Of course I still saw only a handful of criminal cases each year. Murder is not rife in England, as in some countries: it is comparatively rare. The London area, which has more than its fair share, gets only about 50 murders a year; and only about 150 to 160 cases—the figure has been remarkably constant since the beginning of the century—occur annually in the whole of England and Wales. This figure is insignificant when set against a total mortality of some 600,000, of which about 90,000 cases come to the attention of the coroners. When, years later, I made an analysis for the Ministry of Health of 20,000 coroners' autopsies that I had performed, 55 per cent resolved into a mere identification of a natural (but until then obscure) cause of death, and another 30 per cent were concerned with the assessment of some kind of accident or injury in relation to death: an accident at home, in hospital, in the street or at work resulting in injury at some date. Some 4 to 5 per cent were suicides, and only 2 to 3 per cent involved injury that raised suspicion or gave frank evidence of crime.

One morning towards the end of 1934 the telephone rang in my small laboratory at Guy's.

"Dr. Keith Simpson? Scotland Yard here, sir. Detective Superintendent Young speaking. We've just been called to a murder at the York Hotel, opposite Waterloo Station, and we'd like your help."

"Why-er, yes," I said, trying to sound calm and collected, "of course. I'll come straightaway. Be there in ten minutes." (Better be, I thought, or they'll call someone else and bang will go my chances of getting a foothold with the Yard.)

Still a very young pathologist, I was thrilled by this first call from Scotland Yard. In fact, I have never lost the thrill of the sudden call to crime, of dropping everything, leaving a dinner party, even getting up at dead of night, to drive to some new case. It might be another Heath, or Haigh or Hanratty, or "nothing", but whatever it turned out to be I never sensed any kind of disappointment or boredom. The life of a crime pathologist is so packed with colour and interest he has no time to get bored—hardly even to feel tired.

Ten minutes later that first morning I drew up in my Rover 14 among the police and press cars outside the very modest little York Hotel, since demolished to make way for the Festival Hall, and walked up the steps to the front door, already guarded by a constable. The pressmen gathered around took not the slightest notice of me, for I was entirely new to the scene: any important murder always had "Spilsbury called in". I climbed upstairs to the first floor. I felt very much alone, but was young enough to be full of confidence.

"Ah, there you are, Doctor," said the tall grey-haired man who stood on the landing. I can see this distinguished Scotland Yard detective, later to become Commander Hugh Young, eyeing me shrewdly, assessing this new recruit, as vividly today as I did that morning.

"A young couple booked in last night," he said, "and the man was seen just after 9 a.m. today running down the steps and over to the station. The manager thought he might be welshing his account, so he went up to the room. The girl was in bed, dead." He led the way in.

I tried to appear calm. I was absolutely green, and I had a shrewd suspicion the Superintendent knew how I felt.

"Before you touch anything, Doctor, let me tell you we've had the photographs done, but Mr. Cherrill, here, hasn't done the place for finger-prints. She was last seen alive at 11 p.m. when they went to bed."

I put my professional bag on the floor. This earned me my first good mark, for it lay in contact with nothing but the tattered carpet where we stood.

MY FIRST MURDER CASE
at the Waterloo Hotel

I just stood there thinking what came next. My notebook, of course! I carefully noted the time, the place, the officers at the scene, then a rough sketch of the girl as she lay in bed, face up, head squarely in the middle of the single pillow of a small double bed, body straight out, arms and legs beneath the counterpane, the face suffused and the mouth very tightly stuffed, gagged, with a corner of the coverlet and with a handkerchief. In those days the pathologist had no "instant" photographs by Polaroid to eliminate the need for a sketch.

This note-taking helped me to steady my nerves, and it also earned me my second good mark. Too many doctors start by pulling things about, disturbing the evidence.

"She's dead all right, Doctor," said Mr. Young with a smile. "The Police Surgeon came in to certify about half an hour ago. You can move the body now, if you want. There doesn't seem to be any rigor mortis."

Of course! He was giving me guidance. How long had she been dead? The body temperature, showing the heat loss since death, and stiffening of the muscles, coming on some five to seven hours after, would help. I had nearly forgotten that timing is almost more important to the police than how the murder was committed. It helps them check on a suspect's statements.

I pulled the counterpane gently aside and inserted a zero-reading thermometer deep into the rectum. It measured 102 degrees F.! Nearly four degrees *above* normal! *The body had warmed up, not cooled!* I could not detect any muscle stiffening—none. What did this mean?

"I suppose it's pretty obvious she died of asphyxia," suggested Young.

Of course. The body temperature rises in deaths from asphyxia (how had I missed those tiny but pronounced asphyxial haemorrhages on her face and brow?) and it had not yet dropped back to normal.

"She can't have died long before that young man ran out at 9 a.m.," I said. "Early this morning." My confidence grew, and I examined her neck. "Those marks look like a strangling," I added cautiously.

"We rather thought so," said Young. (No score for me here.) "Like a right hand, do you think?"

I accepted his guidance. This grey-haired detective had seen more than I had.

"Yes, it would do very well."

And so I felt my way, gingerly, accepting all the helpful comment this grim-faced but kindly old man handed out. Years later he said I had impressed him by my calm and unhurried step-by-step examination. It really was precisely what it was—a practical examination *for me.* I'd passed.

As the years went by and counted off scores of similar situations I grew in confidence for I knew what I was looking at. I learned there was no hurry—the body wouldn't walk away far—I had time: time to get a proper stock of the situation, to do things in the right order, without disturbing a hair or a piece of clothing until it had been recorded and photographed; time to think and talk over the possibilities, there at the scene; not to rush off to the mortuary.

When I started to do medico-legal post-mortems in London in the middle thirties, the standards of work were deplorably low. Coroners had the power by a 1926 Coroners' Act to call "any duly qualified medical practi-

tioner" to perform an autopsy; and most coroners, qualified solicitors, knowing nothing of the technique of such post-mortem work, did just that. "Any duly qualified practitioner." Many without the slightest training in pathology or post-mortem work, without equipment or laboratory resources, some called Police Surgeons since they attended to drunks under arrest, examined assault cases, or looked after the medical welfare of the local police, and a very small handful who found coroners' work profitable financially, were doing the vast majority of post-mortem examinations.

Almost the only persons in England with any real idea what they were doing were the general pathologists in charge of the larger provincial hospitals—like Smith of Exeter, Faulds of Carlisle, Biddle of Ipswich and Grace of Chester—together with two men in London, Bernard Spilsbury and John Taylor, both real pathologists by training and instinct, both with real insight into the problems of obscure death or insurance, pensions, industrial, suicidal and homicidal cases.

Spilsbury in particular showed an aptitude for seeing criminal investigations with the eye of the police, meticulous for detail, a patient investigator with a logical mind for deduction and a gift for picking out the important factors in a case. Although not highly regarded by his academic colleagues, the professors in the medical schools or universities, he was undoubtedly the authority in his subject and an unchallenged expert of the greatest integrity, pretty well unchallengeable. Tall and good-looking, courteous, a lucid but firm witness using as few words as were necessary, he had for twenty years been head and shoulders above anyone in the country in this branch of pathology. His services were called for, and promptly given, in any important crime anywhere in England. "Spilsbury called in" on the placards meant that a big crime job was in the offing. "Spilsbury in the box" meant that the net was tightening. "Fox Guilty" meant that once again this great figure had carried a judge and jury with him.

Well might J. D. Cassels, Q.C., complain, as he did at the trial of Sidney Fox: "It will be a sorry day for the administration of criminal justice in this land if we are to be thrust into such a position that, because Sir Bernard Spilsbury expressed an opinion, it is of such weight that it is impossible to question it." Spilsbury kept no statistics, but would recollect (with an assurance no one was in a position to challenge) that he had "seen such a case on two occasions previously". Counsel were far too frightened of him to challenge his word—indeed, in the Merrett case at Edinburgh, to which Spilsbury had gone for the defence, counsel at one stage addressed him as "Saint Bernard" instead of "Sir Bernard"! It was, as Cassels has remarked, "an unhealthy state".

Spilsbury's world was England. Only three times in his life did he give evidence abroad; twice in Scotland and once in Jersey over a stillborn. He never saw the Americas, never lectured or worked in any part of the British Empire, as it then was, never attended international congresses to meet and sharpen his wits with his famous contemporaries. He never troubled to speak to his fellows: Sydney Smith, Glaister, Webster at home, or Ponsold of Berlin, Gonzales of New York, Balthazard and Piedelievre in France, Mackintosh in South Africa. Not one of them would have asked his advice, for he did not appear to welcome such requests. He had no confidants among his colleagues with whom he cared to discuss his cases; he never took postgraduate visitors on his "rounds" or in court. He stood like a monolith, alone, aloof, respected but unloved; and unmourned, too, when he finally

committed suicide, in his tiny laboratory in University College, London.

Spilsbury had often been called the greatest pathologist of his day. His stature in the practice of criminal pathology was certainly unique and the trust placed in his integrity was not misplaced. The trouble about such careers is that they die, as completely as the men who live them. It is in teaching, training pupils, writings, the media, and in lecture travelling that a lasting repute lies. Spilsbury did none of these things. He never wrote a guide to the subject—the textbooks in forensic medicine had all come for years from Glaister, Littlejohn, and Sydney Smith in the Scottish schools—and his name does not appear in academic literature of his day. He never took an assistant, though at times he was much overworked, and never trained anyone. It was not possible to sit at the great man's feet, far less his bench or table. I would have leaped upon any chance of seeing him at work: "Yes, of course," he would say without a smile. "Some time." But it never came off for any of those who, like myself, followed him in England.

So though I had then five years of laboratory training at Guy's as a pathologist, teaching at some hundreds of autopsies in the hospital post-mortem room, with a modest excursion into research behind me (I had been a Beaney Scholar in pathology and held a Gold Medal in bacteriology), Spilsbury took no notice of my entry into the field of forensic medicine. I was indeed very small fry, and I had no illusions about being "fathered" into practice by him. It would have been entirely out of character. I had to go it alone.

"Issues in General Practice". *A new monthly series for our subscribers in General Practice. Contributions should be sent to The Editor, Guy's Gazette, 16 St. Thomas Street, SE1 9RT.*

THE DOMICILIARY VISIT

Dr. Ray Goulston, Stockwell Group Practice.

The case for a rethink.

The domiciliary visit between general practitioners and hospital consultants on appropriate occasions has long been an integral part of the U.K. medical mosaic. This article argues that in much of inner urban London at least, only an emasculated version remains. Such visits allow a dialogue between the family doctor and his hospital colleague—the personal and family history marinaded with the expertise of the disease process to the mutual benefit of both, but it is suggested that there are much wider spin offs to be gained from this communication.

Mr. E. W. at 92 although housebound with arthritis remained intellectually vigorous and cheerful. His wife had spoiled him for over 50 years and had no intention of relaxing now. Twice in the last six months he had flirted with the local teaching hospital, unique experiences for him. His prostatism had settled without active treatment and his intestinal obstruction disappeared when constipation was eased. Wisely a positive decision was made not to pursue vigorous investigation. Now he was obstructed again and the enemas nurse had given him at home had failed to produce

the required response. Could there be something more sinister? In a three way discussion he confessed "another trip in there will be the finish". The suggestion of a home visit by the surgeon was eagerly accepted.

Negotiations continued intermittently throughout the day and eventually personal phone contact was established. The surgeon's schedule was already overflowing and colleagues were equally pushed. I am sorry he had better come in.

After an anxious night Mr. and Mrs. W. were looking much closer to their ancient years. Taking unfair advantage of their good will I stressed the facilities available at the hospital. The earlier plea was ignored—collusion by old friends. He was admitted.

He failed to settle with conservative treatment and laparotomy revealed an inoperable carcinoma of the caecum. He died 48 hours later. Mrs. W. called at the surgery to thank me for my efforts on her husband's behalf—this is how I learned of his death.

Hospital consultants and general practitioners have long enjoyed fantasies about each other, but reality shows there are a number of genuine problems to be overcome if combined visits are to become a local reality. Consultants are overstretched as clinicians, teachers and researchers—innumerable committees cement any available spare time. The general practitioner is harnessed to his consulting room and wrestles constantly with the telephone and innumerable interruptions—he too is not immune from committees. So there is a bilateral slogan: he is never available.

Is some sort of reorganisation worthwhile? I believe it is. It is a habit to go to church, it is more easily acquired habit to stay home—reversing the trend is not easy.

No one needs to be reminded that the National Health Service is about people. The problem centres on how best the doctor can deploy his limited time in the interests of his overall medical commitments. The number of clinical problems requiring domiciliary visits are few—a handful per year I believe, but when that necessity does arise it is of crucial importance to the patient.

Is Mr. E. W. a fair illustration? Clinically it is arguable but the modern general practitioner expects to make a diagnosis in clinical psychological and social terms. Management must involve these three elements. Looking through the end of the telescope Mr. E. W. must qualify.

What is gained by the consultant and the general practitioner? Whole person medicine is what family doctoring is all about. Pereira-Gray is concerned that there is insufficient emphasis on home visiting by the general practitioner. How much more does this apply to the doctor who works exclusively in hospital—consultant or registrar. We are so accustomed to seeing patients in our consulting rooms—or outpatients—that we forget, if we ever knew, how much can be learned of patients in the security of their own home. The patient has the added confidence of his own environment and we have the privilege to see how and where he lives. At the other end of the spectrum sociologists have demonstrated the extent to which patients are inhibited lying in hospital garb in a hospital cubicle—dehumanised by loss of dignity. It has been suggested that all doctors should visit annually an adjacent outpatients or casualty—it is felt this would have considerable impact on how we manage patients.

It is suggested that domiciliary visits between consultant and general practitioner where the clinical need arises would be to the mutual benefit of all three parties. Since the reorganisation in 1974 teaching hospitals have a major district responsibility so that communication should have a new urgency. The article has tried to show that broad educational gains are also possible.

"Feeling at home", James MacKenzie Lecture, 1977, Pereira-Gray—Journal of The Royal College of General Practitioners, January, 1978.

"Medical Sociology", edited by David Tuckelt—Tavistock Publications, 1976.

"The Future General Practitioner Learning & Teaching"—The Royal College of General Practitioners.

"Clinical Interviewing Skills", by Froelich & Bishop—The C. V. Mosby Company, St. Louis, U.S.A., 1977.

"Learning to Care—Person to Person", by Byrne & Long—Churchill Livingstone.

GUY'S HOSPITAL DENTAL SOCIETY

Presidential Address 10th October

by Mr. M. L. Maberley

The Dental Society warmly welcomed Mr. Michael Maberley to give his Presidential Address titled *"A wondering dentist"*.

Michael Maberley turned down the Royal Dental in favour of Guy's because in the days before U.C.C.A. the Royal's application form was so hazardously complex compared to ours (name, age and sex only) that he felt he'd be far safer here. Having qualified he discovered that dentists must travel *in cognito* at cocktail parties. On one occasion he let slip that he was a dentist immediately to be bombarded by a woman, "Are you any good at screwing?" Not knowing what lay in store Mr. Maberley hesitated a moment and the woman proceeded to ask about techniques of implanting teeth, or in her language, screwing. Wiser for his experience, people who insist on being cocktail bores are now asked to strip and undergo a medical before any further dental history is taken!

Dentists can freely choose their practices and Mr. Maberley went to the sun and seaside of Eastbourne for the first five years of his professional life. Inquisitiveness got the better of him and he decided to return to Guy's as the first full time Registrar in the Department of Conservation. The travel bug now well installed he moved to Jamaica in 1965 for three eventful years as full time Dental Officer. He helped to found the Jamaica Playhouse, the island's first professional theatre which is thriving today. He also grew, developed is probably better, his inimitable beard which was an indisguisable blessing for believing he was older, hence Prof. and not Doc., the islanders gave him 20% instead of 10% discount because they thought him more worthy of custom!

In Jamaica he heard of a man who had staggered into casualty with both his calves lacerated through to the bone but laughing his head off. Apparently this man had been "messin' around" with his brother's wife. The irate husband exploded "I'm gonna get you man" and stormed off to acquire a machette. The injured brother, it turned out, had sustained attack while lying upside down in (his own) bed and was head over heels so to speak!

Work was hard but rewarding, and as many as 100 patients could present for extractions in a morning.

By 1968 it was again time to move, to the islands of Fiji and to the School of Medicine at Suva. Michael Maberley was appointed Senior Clinical Tutor responsible for pre-clinical and clinical training and in addition was Editor of the *Fiji Medical Journal*. The islanders, he explained, are extremely friendly but exceedingly volatile and the President's maxillo-facial unit was rarely empty with around two mandibular fractures a week and at least one middle third fracture a fortnight. There was also opportunity for research into a mysterious legend.

The worship houses are held up by massive wooden structures sunk deep into the ground rather like giant telegraph poles. Excavation had revealed hundreds of human bones lying around the insertions of these pillars—but just whose bones were they? Did they belong to Tongans captured in the tribal wars or were they as fable had it, Fijians buried in ritual fashion to ensure salvation for their souls? Maberley was able to establish that the skulls were of Melanesian rather than Polynesian origin and therefore the legend was probably true.

After six years abroad he brought his family to Cardiff in 1971 and was Lecturer in Oral Surgery until 1973 when he set out for the Cayman Islands as Chief Dental Officer. In fact he was the only dentist on an island with a population of 15,000!

Michael Maberley has been back at Guy's since 1975 as Director of the D.S.A. school, Assistant Dental Surgeon for the care of the handicapped and General Practitioner in Conservation.

His travelling history was as he put it illustrative of the many and varied opportunities for dentists. Characteristically modest, were his own feelings on wondering what he was doing as a dentist when he felt he had contributed so little and enjoyed so much.

We wish him all the best for his year of office—he has certainly been a wandering dentist!

A.P.

THE FOUNDING OF DENTAL SURGERY AT GUY'S

By Frank James Pearce, L.D.S., D.D.S., Late Dental Surgeon, Guy's Hospital

Guy's can probably claim to be the first general hospital in the country to appoint a dental surgeon to its staff, and confidently claim that it was the first hospital to institute a course of lectures on dental surgery; these were delivered by Joseph Fox, who was the first dental surgeon appointed to Guy's, in the spring of 1799, and similar lectures formed a part of the spring course in subsequent years. These lectures were therefore delivered before Guy's possessed a medical school separate from that of St. Thomas's.

Joseph Fox also published a book on dentistry, which is one of the first, if not the first scientific book published in this country, written by a practising dentist. Hunter's great work preceded it by some years, but Hunter was not a dentist. Fox's book was published in two parts. The first part was entitled "The Natural History of the Human Teeth, including a particular elucidation of the changes which take place during the second dentition and describing the proper mode of treatment to prevent irregu-

larities of the teeth, to which is added an account of the diseases which affect children during the first dentition." This was printed for Thomas Cox (at his medical library), St. Thomas's Street, Borough, 1803.

The full title of the second volume, published in 1806, is "The History and Treatment of Diseases of the Teeth, the Gums and the Alveolar Processes, with the operations which they respectively require. To which is added observations on other Diseases of the Mouth and the mode of fixing Artificial Teeth."

The complete book in two volumes is in the Dental Library, and it is interesting to Guy's men to note by the book-plate that it formed part of the library of the Physical Society of Guy's Hospital, which was instituted in 1771 and can claim to be the oldest medical society in London. Fox's book contains thirteen beautiful copper plates, and was dedicated to Henry Cline, who was at that time lecturer on Anatomy, and surgeon to St. Thomas's Hospital. Fox's address at the time was 54 Lombard Street, and there he probably practised.

A second edition, again in two parts of this work was printed in 1814, and is entitled simply: "The Natural History and Diseases of the Human Teeth." On the title page Fox is mentioned as lecturer on the Structure and Diseases of the Teeth at Guy's Hospital, and Surgeon Dentist Extraordinary to their Royal Highnesses the Dukes of Kent and Sussex.

The second edition contained twenty-three copper plates, and in his introduction to this edition, also dedicated to Henry Cline, Fox writes: "An attention to the appearance of the teeth; and a desire to preserve them in a healthy state; and the necessity which exists of procuring relief when affected by disease, are sources of considerable occupation. In the metropolis and large towns, professional men as dentists are enabled to confine their practices to this department alone, but in those situations where surgeons are obliged to undertake medicine and surgery in all their branches, it is necessary that they should be well acquainted with the structure and diseases of the teeth, as of any other part of practice whatsoever." Further on he writes: "Mr. Hunter's publication on the teeth was the first scientific book ever published upon this subject, and as an anatomical work must ever enjoy great celebrity, but not having practically devoted much of his attention to the operations upon the teeth, there can be no reflection upon Mr. Hunter's merit in stating that in many essential points he was wholly but unavoidably deficient; particularly in regard to the right management of the teeth during the second dentition." He also states he found amongst the pupils of Guy's and St. Thomas's Hospitals a great desire to obtain particular information concerning the diseases of the teeth, and it was this which led to his giving a course of lectures. He gratefully acknowledges the assistance he received at that time from Mr. Astley Cooper. We find that by this time he had removed from Lombard Street to Argyll Street. In concluding his introduction, he mentions how gratified he was to find that a second edition was required, and states that during his professional career his great object has been to render this particular line of practice more respectable by engaging the regular surgeon to adopt it, and he trusts that in conjunction with his lectures this work has contributed to that desirable end.

A third edition was published in 1833, after Fox's death, and in the preface it is stated that, notwithstanding twenty years have elapsed since

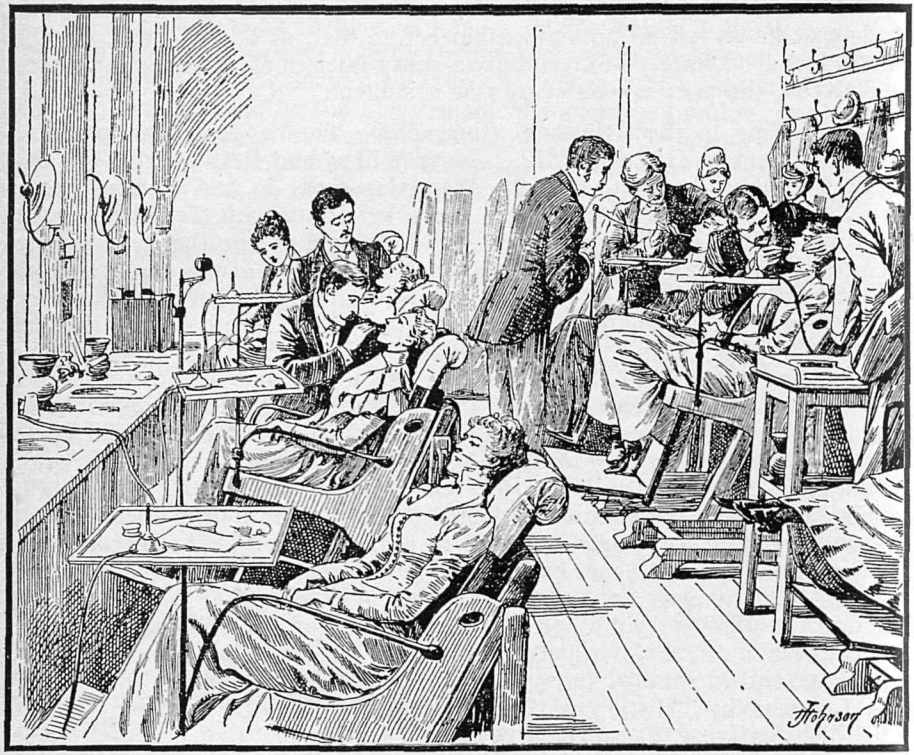
he gave his last attention to the subject, "it is the opinion of good authorities that neither alterations nor additions are required."

Thomas Bell :

The next dental surgeon appointed to Guy's, Thomas Bell, was also a great man: in fact, one of the most scientific men of that time. He was born at Poole on October 11, 1792, the only son of Thomas Bell, surgeon. In 1813, he entered Guy's and St. Thomas's as a student, and we must conclude that he served an apprenticeship before that, as he became a member of the Royal College of Surgeons two years later, that is in 1815, the year John Keats the poet entered Guy's as a student.

According to the "National Biography", Thomas Bell was appointed dental surgeon to Guy's in 1817, though Wilkes and Bettany give the date as 1825. It is unfortunate that the hospital records do not assist us here—probably because at that time there was a very autocratic Treasurer named Harrison, known as "King Harrison", and it is said of him that he appointed members of the staff without consulting the other authorities. Bell remained on the staff until 1861. In 1829 he published his well-known work in two parts: Part I, "The Anatomy and Physiology of the Teeth"; Part II, "The Diseases of the Teeth". He states that Fox was the first to attempt to assign definite terms to the diseases of the teeth, and acknowledges that Fox's was the first scientific book on dentistry. He lectured on Structure and Diseases of the Teeth at the hospital, and in an announcement of the course of lectures for the session 1841–1842 it is stated that one or more courses will be given, and that the fee for each pupil is £2 2s., but that pupils entering to the anatomical lectures will be admitted to these lectures gratuitously. Bell was early attracted to natural history, more especially to zoology, and for some years he lectured at Guy's on Comparative Anatomy, and in 1836 he was appointed Professor of Zoology at King's College, London. In 1837 he published the first edition of his "History of British Quadrupeds", and this is stated to have been written in an easy and attractive style, and in spite of serious defects became very popular. In 1839 this was followed by "History of British Reptilia", and in 1853 by "History of British Stalk-eye Crustacea". A second edition of "British Quadrupeds" was revised and partly re-written, assisted by R. F. Tomes, and this became a standard work. Bell was elected a Fellow of the Royal Society in 1828, and became one of the Secretaries of the Society from 1848 to 1853, and he later became a Vice-President of the Society. He was one of the originators of the Scientific Meetings of the Zoological Society, and for eleven years one of its Vice-Presidents. He was President of the Linnaean Society from 1853 to 1861, and under his guidance the society flourished, and it is stated that it is largely due to him that the society became located in Burlington House, as the Government was originally strongly opposed to this course. Whilst President of the Linnaean Society, Bell presided over the meeting on July 1, 1858, at which the Darwin and Wallace papers on the "Origin of Species" were read. Salter, who later on became dental surgeon to Guy's, was present at that meeting and signed the roll.

Bell was President of the Ray Society from its foundation in 1843 until 1859. He was also President of the Microscopical Society. He practised at 17 New Bond Street, and at the age of nearly 70 retired from practice, and purchased from the grand-nieces of Gilbert White, the naturalist, "The Wakes", Selborne. Here he collected relics and memorials of Gilbert White,



The original Conservation Room. From "Daily Graphic," Oct. 1st, 1883.

and in 1877 he produced his classic edition of Gilbert White's "Natural History of Selborne", with a Memorial to Gilbert White. This was written in his most pleasing style. It is recorded that Bell's manners were most attractive, gaining for him the confidence of the young and old of all classes. His remarkable memory, stored with varied information, remained intact almost to the close of his life in 1880 in his eighty-eighth year. He was buried in Selborne Churchyard, and there is a fine mural tablet to his memory inside the church.

Richard Owen published his "Orontography" between 1840 and 1845, and he dedicates it to Thomas Bell in the following letter, dated 1845: "My dear Bell—Independently of the pleasure with which I embrace this opportunity of expressing the feelings of Friendship and Esteem which I have long entertained towards you, there is no one to whom the present work could with more propriety be dedicated than the acute observer who was the first to point out Pathological Phenomena in the Human Teeth, consistent only with a higher organisation and mode of development than it has been usual to attribute to them, but which it is the chief object of the following pages to demonstrate as common to the teeth of all Vertebrate Animals. I am, yours very sincerely, Richard Owen."

Owen's work was in reality the substance of the lectures on Comparative Anatomy and Physiology of the Teeth which formed part of the Hunterian courses delivered at the Royal College of Surgeons in 1837, 1838, and 1839. Thomas Bell was one of the first examiners for L.D.S. in 1860, John Tomes and Arnold Rogers being the others.

Both Fox and Bell left their valuable collections to the Guy's Museum, and many of them can be examined in the Gordon Museum at the present time: it is, however, some cause for regret that the collections of these famous men were not kept separate from the general specimens.

Samuel James Augustus Salter

was dental surgeon to the hospital from 1851 to 1880; part of that time, from 1851 to 1861, he was associated on the staff as assistant dental surgeon to Thomas Bell.

James Salter, as he always called himself, came from a medical family at Poole, and was born in 1825, the year of the Institution of the Guy's Medical School. He received most of his medical education at King's College; he took his M.B. at London University in 1849, and the M.R.C.S. and L.S.A. in 1847; was house surgeon at King's College, acting in that capacity to the celebrated Fergusson. His uncle, Thomas Bell, induced him to specialise in dentistry, and he eventually joined him in practice. In spite of a busy practice, he found time to interest himself in scientific matters, and was an active member of several societies. He was the author of a paper read before the Philosophical Society on the "Structure of the Tooth of Echinæ", and in 1863 became a Fellow of the Royal Society; he was at this time already a Fellow of the Linnæan Society. In 1874 he published his work on "Dental Pathology and Surgery". This book did not pretend to be a complete treatise on the subject, but was probably really an elaboration of the lectures which he delivered at Guy's, together with many original and thoughtful observations, and it is even to this day a book which is well worth referring to. Salter was, in addition, a good botanist, and several papers of his are recorded in the *Linnæan Society's Transactions*, some of

S. J. A. Salter, F.R.S., M.B., M.R.C.S., L.S.A.
Dental Surgeon 1851 - 1880

which contain original discoveries. On retiring from practice he went to live in the country, and occupied himself with farming and other rural pursuits, possibly with hunting, as he had been a very regular member of the Meet, even whilst in practice. In addition to these pursuits, he is said to have amused himself with the study of heraldry and archaeology. He seems to have been a most amiable man and a delightful companion. He married late in life, but his wife predeceased him by a year or two. He died in March, 1897.

There are many papers written by him in the *Guy's Hospital Reports.* In the volume for 1852, there is a paper on Dentine of repair and the laws which govern its formation, illustrated by two plates. In the volume for 1855, there is another on The intrinsic calcification of the permanent tooth pulp, constantly associated with dental surgery as distinct from dentine of repair. In the volume for 1856, there is an account of a large myeloid epulis in the lower jaw, and in 1858, there are further contributions to dental pathology on the shedding of the teeth and exfoliation of the alveolar process consequent upon eruptive fevers, on warty teeth, and on polypus of the tooth pulp; in the volume of 1860, a case of ovarian tumour containing teeth, hair, etc.; in the volume of 1866, on Teeth as passive organs of speech and several others.

As stated above, he practised with Thomas Bell at 71 New Broad Street, and he also acted as examiner in dental surgery at the Royal College of Surgeons. It has been said of Salter that had he confined his talents purely to the study of scientific matters, he would have made a great name in science.

Henry Moon

Assistant dental surgeon from 1870 to 1880, and full dental surgeon from 1880 to 1887. Henry Moon was the son of William Moon, a doctor in practice at Tottenham. He was always of rather delicate health, and Dr. Braxton Hicks advised him to take his medical qualification with a view to specialising in dentistry. He came to Guy's as a medical student, took his L.S.A. in 1862, his M.R.C.S. in 1866, and then studied at the Dental Hospital, taking prizes there, and his L.D.S. in 1867. He was appointed assistant dental surgeon to Salter in 1870, and on Salter's retirement he was appointed dental surgeon and lecturer on Dental Surgery. He was in addition dental surgeon to the Dental Hospital.

He was author of a section on Dental Surgery in Bryant's "Practice of Surgery." In the *Guy's Hospital Reports* of 1873–1874 he writes on mechanical appliances for treatment of fractures of the jaw. In the *Transactions of the Odontological Society* there is a communication by him on a method of pivoting; he became a Vice-President of this Society.

His health, which was never good, failed, and he went to visit his brother in New Zealand, and while he was away his appointment was kept open for him, and it was during this time that Newland-Pedley did much of his earlier work at Guy's, practically acting as dental surgeon to the hospital. Moon returned to England, but died on November 14, 1892.

The Foundation of the Dental School

In the May of 1877 there entered Guy's as a medical student a man who was to revolutionise entirely the dental work of the hospital, Frederick Newland-Pedley, the son of a dental surgeon, practising at 12 George Street,

Frederick Newland-Pedley

Hanover Square. His father was forced by ill-health to give up his practice in London in 1872, and went to Australia with his family. It was destined, however, that the son should return and become the founder of the Guy's Dental School.

Having already assisted his father for four years, on Moon's suggestion, he entered as a student at the Dental Hospital in Leicester Square. He passed his L.D.S. in 1880, Salter being one of the examiners. He then passed his M.R.C.S. in 1881, and later his F.R.C.S. in 1885. During the time he was reading for his fellowship, he did a good deal of coaching for men going up for the dental diploma from Leicester Square, and also acted as an unofficial assistant to Moon; he was always a good teacher, and it is his proud boast that only two of his students were referred. He then started practice in Finsbury Square, close to Moon, who shortly afterwards removed to 112 Harley Street.

Newland-Pedley was appointed assistant dental surgeon to Guy's in 1885, and Moon came to leave more and more of the work to him. He soon became ashamed of doing nothing but extractions and began to undertake fillings; more particularly among the students. In 1887 he was appointed dental surgeon to the hospital. This gave him the opportunity to extend the work he had endeavoured to further whilst helping Moon—the reform of the out-patient dental surgery at general hospitals by the provision of conservative treatment. He realised that to confine the work to the extraction of teeth was comparable with the restricting of ophthalmic surgery to the removal of eyeballs.

The authorities having granted him a special room, with two dental chairs, he ran an improved department at his own expense, even defraying the cost of the "gas" used. He enlisted such help as Wynne Rouw had time to give, he having taken his L.D.S. in 1885 and being, at this period, busy completing his "Conjoint". Very soon, in addition to an ever-increasing out-patient attendance and work in the wards, he was overwhelmed with requests for "fillings" from students, sisters, and nurses, and it was borne in upon him that he could not survive without student help—and lots of it.

This meant a dental school. His original draft of a scheme for such a school was written, whilst on holiday, in the Paris Louvre, and he brought it before a Staff Meeting in May, 1888. It was referred to a Committee, of which Clement Lucas was Chairman, for consideration and report. The matter came up again a month later, and was referred back for further consideration.

In July, an amended and fuller report, signed by Arthur Durham, making recommendations as to the staff and their duties, was approved by the meeting and sent forward to the Court of Committees.

On December 12th the Court of Committees met, the Dean, Cooper Perry, and Newland-Pedley being present. The Treasurer, Mr. Lushington, presented a memorandum in favour of the establishment of a dental school. It was finally approved by the Governors on December 19th, 1888.

In less than a month after this decision was made, a letter was received by the Dean from a prospective student, the result being that, on February 7th, 1889, Montagu F. Hopson signed the roll in the Medical School Office and thus achieved the distinction of being the first member of the school.

The carrying through to a successful issue of Newland-Pedley's scheme

was by no means such a simple task as might be inferred from the brief summary given above. As was to be expected in those days, it did not receive the unanimous support of all his colleagues at the hospital, and he had also to contend with strenuous opposition from outside vested interests. Letters and articles appeared in the medical and dental journals, which form interesting reading today.

Arguments were put forward to show that another school was not needed and that the special dental hospitals were quite capable of dealing with the demands of both patients and students. Newland-Pedley, however, was too far-seeing and astute not to have reconnoitred the ground. At his instigation, all his overflow patients at Guy's were sent on to one of the dental hospitals—and to use Newland-Pedley's own words, "we filled even their staircases. The Dean wrote to say that such patients could not and would not be attended. When I was called before the Court of Governors the question was raised as to whether the dental hospitals could not supply all necessary treatment. I was questioned closely, and eventually I drew from my pocket the Dean's letter. There was some suppressed merriment in the Court and a little coughing."

The Editor of the *Lancet*, in a somewhat carping annotation (January, 1889), inferred that the proposed school was likely to involve a heavy burden on the funds of the hospital.

In other quarters it was hinted that Guy's would be unable to secure quite the right type of men to serve on the staff.

Newland-Pedley was not mistaken in advancing his scheme: he had in view two main ideas, the benefit of hospital patients and their efficient treatment and the advancement of dental education. He was indeed fortunate in having amongst his colleagues some very active supporters, and, above all, one brilliant organiser and administrator, Dr. (now Sir) Cooper Perry. The writer cannot refrain from quoting the following tribute from Newland-Pedley.

"About three weeks after the publication of my dental school scheme I met Dr. E. C. Perry for the first time. From that time we collaborated in establishing the school, and in all the reports that followed the hand of Cooper Perry can be recognised. Unlike myself, he was already a man of note who had accomplished public work, and his successful efforts in creating the College had already revealed to our Governors those unlimited powers of organisation and administration that carried him from one great work to another with an ever-increasing benefit to the hospital, until the time arrived when it was truly said that he had left his name written on every wall of Guy's. For the first five years the work was continuous, and Cooper Perry being Dean of the dental school, everything had to pass through his hands, and I did my share, with other pilgrims, in wearing out the carpet in the Medical School Office.The dental school must never forget what it owes to Cooper Perry, and that throughout those years of labour he was acting from the most unselfish motives.

"In the dental school he foresaw an institution that would be a benefit to the hospital, the patients and the students, and that was all, for he well knew that his own destiny was calling him to a higher sphere of action than ours."

Continuing our occasional series "Outside Guy's" . . .

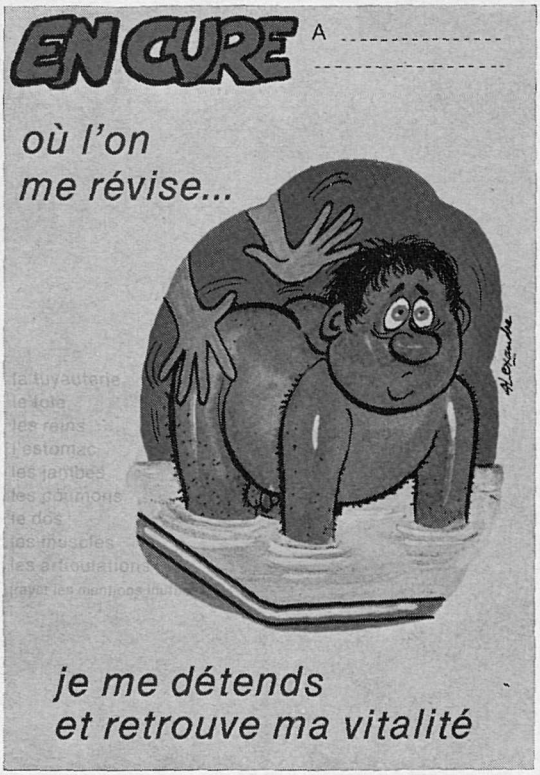
IN PRAISE OF FRENCH SPAS.

by Camilla M. Haw

Some of my best friends are hypochondriacs. But doctors die young these days—we're an "at risk" profession. Bearing these facts in mind, a band of ageing twenty-four year olds set off for France and three glorious weeks of recuperation. Our plan, if we really had one, was a gentle jaunt around the countryside, indolently encompassing some thermal stations. England abounds in spa towns—Bath, Harrogate, Tunbridge Wells, Malvern . . . the list is endless but "to take the waters" here you have got to be barmy or feeble-minded at least. The English avidly consume pink medicine instead. But the French are different and are mad keen on *la thalassothérapie,* though they do enjoy a good suppository too. Around half a million Frogs flock to spas each year and the government takes it all very seriously, incorporating *la thermalisme* into the social system.

We perused the guide books for inspiration. You have to have the right sort of ailment to benefit from a spa, no nasty tumours or infectious diseases. The best sort of malady is something pretty chronic and unspec-

tacular, the kind of dregs that have been coming up to out-patients' for the past fifteen years. Choice of spa is important too—Chatel Guyon describes itself as *la capitale de l'intestin* and Vichy is for liver complaints. Evaux-les-Bains specialises in rheumatism and all things gynaecological. Asthmatics have a vast choice and it is difficult to know where to recommend.



In the end, we plumped for St. Nectaire, a modest station high up in the Auvergne. Its forte is kidney disease—failed renal transplant patients take note. The day was hot and sultry as we plodded our way along the tortuous approach road. The village sat in the centre of a valley surrounded by horned white cattle, snowy peaks and dark, wooded slopes. Cotton-wool clouds floated overhead in a cerulean blue sky. We wandered past the plentiful distractions—the casino, the inevitable tourist shops and the sleepy cafés with their gay umbrellas and white lattice tables. Eventually, we happened upon one of the sources, and keen for a cure, we stepped forward to have a drink. However, our noses suddenly registered one almighty stench —all very French but exceedingly unpleasant. Disappointed, we retreated into one of the cafés for a drink of strong coffee. It came black and bitter in dainty dark green cups with gold rims. As I sat and wrote some naughty postcards home, I thought how nice to linger here in one's uraemic years.

Le Mont-Dore was our next stop. There, we goggled at the asthmatics taking their cure. The vaporarium conjured up shades of "Brave New World". The patients sat, white-suited, in long lines each attached to and breathing from a mask. I suppose they enjoyed their collective inhalation for their expressions were curious and hard to interpret.

We journeyed on to Vichy, so called "queen of watering places". The town has almost two hundred springs so we reckoned it would be fairly easy to find one to our liking. The Source de L'Hopital looked clean enough and so we filled our empty yoghurt cartons and drank . . . The peace was shattered by a hysterical Frenchwoman. We were doing something terribly wrong, absolutely forbidden. We would die, be very ill at least. The waters were very strong, poisonous in excess. The doctors recommended a maximum of 30mls. a day and our cups contained much, much more. We blushed and thanked her for her trouble but she need not have worried for the water was fairly disgusting. It tasted like old dishwater and none of us could stomach more than a few mouthfuls. We consoled ourselves with an ice cream in one of the many enticing pavement cafés, but we were stung for a pound each and on paying the bill made a bee-line for the car. Vichy was just too expensive for us poor men of Europe. As yet, we were not affluent consultants but merely lowly students. So, I concluded spas are good places in which to go into a gentle decline but make sure your pockets are well lined first.

PUPIL'S PHYSICAL SOCIETY

Professor Harold Ellis on "Royal Operations"

Thursday, 27th September, 1978

Like most doctors, Professor Ellis enjoys a good gossip, and what more promising material can one think of than the monarchy, their afflictions and operations? Ever since his days as a medical student, Harold Ellis has been gathering together little snippets of medical news from the royal households of Europe. The result is a humorous and fascinating collection of anecdotes which we at that, "second best medical school in London", were privileged to hear.

Imagine the scene on Wednesday, 9th November, 1736. Queen Caroline, wife of George II, lies distressed and vomiting in the royal bed-chamber. Six pregnancies and numerous gluttonous banquets have turned this once slim and fair lady into an obese and ugly ma'am. However, intemperance has reaped a more sinister toll for the Queen now has colicky central abdominal pain. The royal apothecary is called. He unctuously bleeds, purges and applies enemas to the patient but to no avail. He is dismissed as a failure and on the Friday a surgeon is summoned. John Ramby arrives to find the Queen moribund. On slipping his able, hairy hands beneath the royal bedclothes, he fumbles upon a strangulated umbilical hernia. Ramby decides to operate but in view of the patient's poor general condition he opts for a conservative procedure, namely lancing the fundus of the hernia. Sadly, the operation is a failure and by the Sunday signs of gangrene have appeared. The Queen lingers on for another week before the strangulated loop of bowel bursts and she succumbs to her demise.

When George IV developed an occipital sebaceous cyst it was a young Guy's surgeon, Astley Cooper, who had the dubious honour of removing it.

Cooper was summoned to the Royal Pavilion, Brighton and arrived in the middle of the night to be led into the King's bedchamber. There, in bed, sat George IV who suddenly doffed his nightcap and demanded an operation there and then. Young Astley was anxious to secure more favourable operating conditions. He persuaded the King that London and daylight were required for good surgical technique. The cyst was duly excised and George IV made an uncomplicated recovery, save for an attack of gout on the second post-operative day. No doubt this was precipitated by over indulgence in the post-operative port. Astley Cooper was made a baronet and thereupon embarked on a distinguished surgical career. In 1817, he became the first person to ligate the abdominal aorta. The patient might have lived had he not also ligated one femoral artery. Unfortunately, the affected limb became gangrenous and the patient perished. Strangely enough, the specimen from this historic operation is still to be found but in St. Thomas' Hospital. Astley Cooper's fanatical dedication to his subject carried a price and his wife left him.

Professor Ellis ended with a little advice on the handling of royalty and other V.I.P.s—give them the same good treatment as your ordinary patients and you won't go far wrong. If I were the Queen, I'd certainly send for Professor Ellis, for to consult a man of such wide knowledge and wit must be a real pleasure.

C. M. Haw.

THE STUDENT MEDICAL EDUCATION COMMITTEE

"Remember, remember the 1st of November."

Using less sensational ways than gunpowder, treason and plot, the S.M.E.C. elections nevertheless provide medical students at Guy's with the opportunity to explode the myth that they are apathetic about their own education in Medicine.

On November the second, the ballot boxes will be out for electing two students from each year to serve as representatives on the 1978/79 Student Medical Education Committee. At Guy's in the past six years student opinion, where it is properly assessed and effectively channeled, has proved to be a very powerful influence in the planning and modification of the new medical courses (B.M.S. and clinical) that have been introduced.

The main role of S.M.E.C. is to be the voice of students in these matters. It is not a voice crying in the wilderness because representatives from S.M.E.C. sit on all the planning and co-ordinating committees of the Medical School concerned with the teaching of medicine.

Important improvements in education at Guy's do not occur overnight, but with consistent pressure from successive committees changes *are* brought about. Over the past year the retiring committee has conducted a questionnaire on aspects of the Preliminary year and two questionnaires on important issues in the new clinical course. Armed with the results of these questionnaires it has tried to put forward practical proposals for improvements in each area. Issues raised on the clinical course have been the teaching of surgery, the length of the medical and surgical firms, the pathology course and its length, the position and quality of various specialties, the sign-up system and the need to establish some sort of revision course to improve the poor finals results.

Issues concerning the B.M.S. course pursued by the committee have been the teaching and exam structure of the Biochemistry course and the teaching of pathology in the B.M.S.

To identify the problems is only the beginning, continued effective representation, imagination and stamina will be needed in the quest for *improvement.*

The success of any committee rests on the right people putting themselves forward to serve, and for their year to *vote* for them. If you have an interest in your own medical education, you could be that "right person". The least interest you can show is to find out who the right people are to represent your year and to vote for them on November 2nd.

Paul O'Hare.

FILMS AND THEATRE

Getting it right is, as Arthur (brother of Alfred Lord) Tennyson once said, what it's all at. So turning up to the Old Vic to see "The Lady's Not for Burning", only to find that **Twelfth Night** was on, might seem a little like getting it wrong. Then again, that might be just the sort of shoddy service that you ought to expect from an unsubsidised Films and Theatre Column. Yet I shall "hold my peace", for the play doth seem to begin—

A group of players straggle onto the stage, the drummer has "Illyrians" on his drum, an ageing hippy snaps his fingers and . . . Twelfth Night is somewhere between Bohemia, Elysium and the 1930's to judge by the costumes.

It is a romp; the music is catchy, the acting is uniformly perfect (particularly the reluctant transvestite Viola) and the director must have had some fun too. The production may not tap the full tragi-comic depths of the play, but it will certainly keep you amused. It has some surprises too. Feste as a tall faded hippy is novel and sinister at times. Sir Andrew Aguechieke is a 30's slicker in a Harold Nicholson suit and trilby, being, but never getting, the joke.

The laughs are not always Shakespeare's—for instance, Sir Toby, Andrew and Fabian pose as Classical statues to overhear the pompous steward Malvolio's discovery of his lady's feigned love letter (every time he turns round the fearful three freeze into Classical musical statues with the help of Classical drapes—courtesy of the props department).

If it is not to the letter, the production is certainly in the right spirit—every line that can be played for laughs and more is done so—every hint of a lyric is sung to the hummable strains of the omnipresent Illyrians. While Maria, Toby and Sir Andrew emerge the wiser, when their pranks turn sour, most of the serious characters are believably in love—and if a certain depth and "high sentiment" are sacrificed for laughs (certainly in Olivia as she stoops to conquer) who cares in this musical Elysium?

The Prospect Theatre Company, rather like the Aldwych and the National varies its programme from day to day and we shall, with a little luck, by reviewing "The Lady's Not for Burning" in the next issue. On the other hand if 2½ hours of sentimental and hysterical slush is your line, then so is **The Unmarried Woman** (Odeon, Kensington). Don's be confused—the

unmarried woman isn't unmarried at all. She's married to 17 years worth of hulklike all-American businessman, a precocious 15-year-old daughter, a smart New York apartment, a part-time job in an art gallery and a gaggle of middle-aged harpies, who specialise in talking sex and sentiment over considerable amounts of booze.

The bottom falls out of her world, when husband excuses himself with a bird from Bloomingdales, and falls back in again when Alan Bates, in the part of natural man and abstract (if not abstracted) artist finds that she is the only one for him. That is except that he can't interrupt his work schedule for her in case he loses his urge (artistic). His work, I might add, consists of turning whole pots of paint upside down onto large stretches of canvas, on to which other pots have similarly been turned upside down.

This is clearly not a man's film, or at least I should say that I don't think it was, having dropped off, when our neurotic heroine went to see her all-American therapist. As to those inner depths of female sensitivity and perception, to judge from my escort, they are given no greater task than to gaze fondly at the bulging hairiness of Alan Bates' body.

Michael Dixon.

J. J. E. writes, the **Revenge of the Pink Panther** is a delightful comedy in similar vein to previous Panther adventures. Although merely a vehicle for the antics of Peter Sellers in various disguises, the plot keeps moving and no gag is prolonged too far. The scene where Sellers is disguised as Long John Silver with a leaky, inflatable parrot on his shoulder is brilliant and as the Mafia boss, he is better than the Godfather himself. Wonderful slapstick abounds, always amusing and yet never hysterically funny, this is deservedly the number one movie in London. See it if you haven't yet, but I expect you already have.

The Wild Geese is a rough, moody film about a bunch of mercenaries contracted to kidnap and fly out an ailing black president held captive in Africa. Roger Moore, Richard Burton and Richard Harris are suitably cast as tough guys and they go through all the motions convincingly. The film even has one or two amusing scenes. It is a little spoilt by its stilted attempt at rationalisation of mercenaries and in the film's efforts to be meaningful come its most turgid moments. Anyway, there's plenty of nail biting blood, guts and excitement and the film is well worth a visit, especially if you've just lost a Rugby match.

So much has been written about **Grease** that it comes as quite a surprise that it really doesn't deserve much acclaim. Billed as a love story between the naive and simpering Olivia Newton John and confident leather bound John Travolta (megastar) the film fails due to its extraordinary lack of content. The script is mostly dull except for one or two moments such as when Olivia Newton John sighs

"I'm no stranger to hardship," and her girl companion replies

"Why? have you got psoriasis?"

Or one of the greasers who says that girls are only good for one thing (nudge, nudge) and his mate replies,

"So what do you do with them for the other twenty-three hours and forty-five minutes of the day?"

There are four good pop songs in the film all of which will have reached

number one in the record charts by the end of October and so the relevant parts of the film can be seen on Top of the Pops. The other songs are all fillers often totally out of context and all very weak. There is of course the one brilliant pop song "You're the one that I want" which will always be a classic and should have ended the film. Instead of this the ending is totally puerile. Travolta is good there's no denying and the best that can be said about Olivia Newton John is that she is very decorative and tries very hard. However, I recommend you just watch the four hit songs on Top of the Pops as you can guess the whole plot (there isn't one) and see all the best scenes free of charge.

NURSING

The Details of Nursing

One of the Nursing journals recently published an editorial in which the importance of routine care and attention to detail in the work of the nurse was stressed.

The article also stated that the majority of patients are not dying, nor do they require intensive care. They simply need basic nursing. Why then, are nurses so reluctant to give this?

Most student nurses express a desire to "help people" when they commence their training. All too soon after, those same students are complaining of boredom, because the ward in which they are working never has any dramatic incidents. Further investigation however shows that the nurses have discovered very little about their patients, that they never talk with them, and feel that providing basic comfort is beneath their dignity.

Attention to detail is not something on which very great importance is placed nowadays. Schoolteachers reject the idea as unnecessary and inhibiting to children. They maintain, quite falsely, that with increased maturity, pupils will develop the trait spontaneously. Usually, of course, this is due to their own carelessness, having never been taught, from an early age, to be meticulous. Student nurses do therefore, experience extreme difficulty in adjusting to their responsibilities and the maintenance of care necessary for the comfort of the patients. This attitude is reinforced when they observe their Senior Colleagues condoning poor nursing. In addition the ubiquitous complaint that there is no time to carry out duties conscientiously also serves to a lowering of standards. The argument as to whether nursing is an art or a science, an academic or non-academic career, is, and always will be irrelevant. If patients are to receive care which is safe and adequate, and which provides comfort, it is essential that nurses attend to the details. It is very laudable for the student to be able to give an erudite description of a patient's medical treatment, but how much better it is if she can make him feel that she actually cares about his welfare.

Pam Jefferies.

Paper Wastage, Pay and Professionalism

Nurses obviously have to provide a 24-hour service and the inconvenience of being on duty between 8 p.m. and 8 a.m. and at weekends is rewarded by a higher rate of pay (time and a quarter). For a long time nurses have been required to fill in a green form once a month, stating the "unsocial hours" worked, and when this form has been countersigned by a sister or nursing officer, the finance office will make the extra payment. It could be argued that for nurses in training this exercise is a waste of money. In a year everyone does about the same number of nights and weekends on duty and a standard extra payment could be made. A considerable number of paid hours must be used in the finance office to process all these forms.

However, far from trying to improve this absurd system, the finance office have recently made it even worse. The green forms have now been abandoned in favour of yellow ones of a slightly different design. What will happen to the green forms? Presumably they will suffer the same fate as most of the pieces of paper produced by the N.H.S. The yellow forms have to be completed and countersigned once a week; if a single countersignature is used for the whole month, the form is returned. The nurse has to draw a line through the space for any day on which she has not worked unsocial hours; if a space is left blank the form is returned. Time and a quarter is not much, but as the nurses cannot afford to forgo even that, they have no choice but to obey these regulations.

Much is talked these days about improving the image of nursing as a profession, certainly this sort of procedure does nothing to make a nurse think of herself as a professional person; it can only be a matter of time until the finance office has us clocking in.

Julia Fabricius.

Engagement Rings, Jewellery and Watches

20% – 25% DISCOUNT
To all Hospital Members and Staff

JEWELLERY
Gold — Wedding and Signet Rings and Jewellery.
GOLD AND SILVER—Dress Rings and Chains, Bracelets, Necklaces, Charms, Brooches, Earclips, Links, etc.
OPEN 9—5. Sat. 9—12.
Special attention to orders by post or phone. Remodelling and Repairs to all Jewellery and Watch Repairs.

10% – 20% DISCOUNT
To all Hospital Members and Staff on all Branded Goods
SWISS WATCHES
CLOCKS, SILVER, E.P.N.S., TEA SETS, LIGHTERS, ETC., AND SECOND-HAND JEWELLERY.

GEORGES & CO.
OF HATTON GARDEN
(ENTRANCE IN GREVILLE ST. ONLY)
88-90, HATTON GARDEN, E.C.1.
01-405 0700 and 01-405 6431

PHYSIOTHERAPY

There have recently been, in the newly-developed paramedical press, accounts of a report of the "Joint Remedial Professions Course" run by the Polytechnic of Central London, the London School of Occupational Therapy, and the Physiotherapy Schools of the Middlesex and St. Mary's. This course, which has existed for four years, was confined to the first year of training and has culminated in an examination, moderated by external examiners appointed by the professional bodies, which was recognised by those bodies as equivalent to their own Part I examinations.

Physiotherapy and Occupational Therapy students, in roughly equivalent numbers, have shared lectures, and practical classes in anatomy, physiology and behavioural sciences conducted by the staff of the four institutions, backed up by tutorials in their own Schools.

It was recognised that geographical realities militated against a truly "Joint" course with schools as far apart as Swiss Cottage and Paddington. The consequent centrifugal tendency not only separated the students by future profession but also by hospital affiliation, and certainly discouraged mixing between the health-orientated students and the other polytechnic students. Different educational backgrounds, different future employment, different philosophies, different locations . . . The project was doomed to failure, but yet failure could not truly have been said to result. If we ignore the students—and what teacher has not earnestly desired that boon in his time—the staff of the four schools were agreed that the sharing of experience, the rigours and disciplines of not only determining the common core material, but actually writing the educational "packages", had enlarged their vision and taught them to appraise themselves more objectively.

It would be misleading to read too much into the success and shortcoming of this pioneering enterprise, given the circumstances in which it was realised. Certainly it showed that, at least for a year, it was possible to teach common subject-matter to different groups of students. This, one might say, must surely have been obvious from the outset, but anyone who has wrestled with the apparently insoluble problems of depth, emphasis and weighting of two or more ostensibly identical programmes of teaching for different groups will appreciate that that is not so.

Of course, it could be argued that togetherness is more appropriately started post-registration or at most in the latter stages of training, but that is a nettle that remains to be grasped, and such evidence as has been forthcoming from moves to amalgamate qualified remedial gymnasts and physiotherapists is not encouraging.

Be that as it may, one of the Physiotherapy Schools, the Occupational Therapy School and the Polytechnic are intending to keep on trying, and one cannot do other than wish them well.

P.S.: Occasionally I meet people who are kind enough to tell me that they read this page. They must have been hard put to it to make sense of it in September when the second half preceded the first. So, please, it was not just the impenetrable prose of the author that was at fault but the whim of the printer that made rungs, rings and epilogue, prologue.

Ronald Cooper.

P.P.S.: My sincere apologies are due to Mr. Cooper.—*Editor.*

BOOK REVIEWS

"The Placebo Effect in Healing", by M. Jospe. Pp. 170. Price £11.50. Published by Lexington 1978.

Some of the actions of drugs are not related to the biochemical properties of the drug—but to the patient's perception of the doctor prescribing the drug, its route of administration and physical form. Even in serious organic disease—such as angina pectoris—more than a third of patients may experience relief from symptoms when given a pharmacologically inert substance. It is about the placebo response that this book is written.

In the acknowledgements Michael Jospe describes himself as a Psychologist who has been associated with the University of Minnesota Health Care Center.

The content of this short book is worthy of such an important topic. Its main merit is an excellent review of the literature for the past 20 years. The areas covered extend beyond drugs and include placebo studies in psychotherapy, a discussion of the personality of the placebo reactor and methodological problems.

The book should be of interest to anyone who treats patients by any technique but will be of most value to those designing clinical trials of new drugs.

R. G. SPECTOR.

"Nutrition in Action", by E. A. Martin and A. A. Coolidge. Pp. 531. Price £10.40. 4th ed. Holt, Rinehart and Winston, 1978.

If you live in North America, are a school teacher, or "an adult in search of scientifically reliable information on nutrition", then this book could be very useful and valuable to you. It covers in a general way, all aspects of nutrition from nutritional status, through simple metabolism, and applied nutrition to world nutrition programmes. The style is pleasant, the tables and line diagrams very good and the whole is well produced. In such a wide coverage it would be unusual to expect no errors, and therefore the English will learn with amusement that they were responsible for pecan stuffing in turkey! Of a more confusing nature is the use of calories in some tables and kilocalories in others, when I presume they mean the same energy unit.

Though the authors have put together in an acceptable but superficial way, all aspects of nutrition, it is not a book that is aimed at the readership of the Guy's Gazette.

I. MACDONALD.

"Medical Acid-Base Balance. The basic principles", by M. L. G. Gardner. Pp. 125. Price £3.95. Published by Bailliere Tindall, 1978.

As every medical student knows acid-base balance is not easy to grasp, but as disturbances of this balance are so important and as they occur so frequently in clinical medicine, it is vital that it is understood. This book makes a very good attempt to do this. It explains the physiology of acid-base balance in simple terms—or as simple as they can be in such a complicated matter, and it also gives examples of clinical situations where this balance is disturbed, how this came about and what to do about correcting it.

It is not easy reading as might be expected of the topic, but the facts are presented logically and well reasoned. It is not the book for anyone who wants an "instant" understanding of acid-base (can there ever be such a book?) but it is the book for those whose speciality brings them in contact with patients likely to suffer from pH disturbances and obviously to anaesthetists, intensive care and renal physicians it would be especially useful.

I. MACDONALD.

"Pathology of Peripheral Nerve" (Vol. 9 of "Major Problems in Pathology"), by A. K. Asbury and P. C. Johnson. Pp. 311 + xiii. Price £15.00. Published by Saunders, 1978.

This book extensively covers the morphological pathology of the peripheral nervous system in brief and concise form. There are also valuable basic and technical chapters. However, brevity has perhaps been overdone in some chapters, viz. Hirschsprung's disease is presented in a chapter of thirteen lines. None of the recent diagnostic features of and methods for this disease have been described, and other ganglion disorders (e.g. achalasia) seem to have slipped attention. More chemical and immunological information could have been included to add perspective to the morphological approach. Nevertheless, this should prove to be a useful book for pathologists. The price is a bit forbidding, but the illustrations and quality of paper are excellent.

C. W. M. ADAMS.

"Genetics", by Ursula Goodenough. 2nd edition. Pp. 840. Price £7.50. Published by Holt Rinehart and Winston, 1978.

The present day choice of genetics textbooks can be somewhat bewildering, and it is a relief to find one that can be recommended without too many misgivings. The new edition of Genetics, by Ursula Goodenough is one such book. Most aspects of the subject are covered to a greater or lesser extent, but the emphasis is strongly biased toward the molecular, while the currently important fields of viral and bacterial genetics are covered in considerable detail. These are in fact topics which quite a large proportion of students find particularly difficult, and although the coverage of them is in far greater detail than would be required by a student of medicine, the book is so well laid out and cross referenced that it is ideal, if not for a course manual for them, certainly as a very helpful reference book. Moreover, unlike most reference books, it is extremely readable.

The author has the rare gift of discussing complicated topics in a logical, concise and interesting manner. In addition to the generally very clear figures and tables are the boxes, which are essentially expanded footnotes to explain terminology or procedures, or to act as a reminder of relevant background facts. They are a feature which I felt was especially useful.

Apart from some minor reservations regarding the quality of a few of the chromosomal figures, I would strongly recommend this text as a reference book for the medical student, while at £7.50 it is excellent value for money and would provide a good up-to-date manual for the student taking a general genetics course.

M. G. DAKER.

"A Short Textbook of Medical Microbiology," by D. C. Turk and I. A. Porter. 4th Edn. Pp. 388. Price £3.45 (paper), £6.45 (hardback). Published by Hodder and Stoughton Unibooks, 1978.

This book continues to be the cheapest, most concise, readable and up-to-date account of medical microbiology for medical students. The role of this series of University Medical Texts is nicely summarised by the General Editor, Dr. Selwyn Taylor, whose wish was that the books should be "inexpensive and compact, should fit in the pocket of a white coat and become faithful friends—so well used that they would begin to fall apart when three or four years old and we could then provide a new edition." This fourth Edition is an admirable compromise between the need to convey new ideas, to be relevant and accurate, without getting bigger and bigger. The fact that it has 10 per cent more pages than the previous edition is largely due to an increase in type size. The authors have shortened the section on Immunology because cheap and excellent paperbacks on this subject are available (and which medical students should possess). There are also greatly improved chapters on the vital subjects of taking specimens and on Antibacterial Drugs. I have always thought that the few pages on the meanings of abbreviations are a particularly good idea. In a word, it is a fine book, now a bit heavy for the pocket of a white coat, but recommended for all medical students.

C. A. MIMS.

"Viral Hepatitis", by S. Krugman and D. Gocke. Pp. 147. Price £12.25. Published by Saunders, 1978.

This book is number 15 of a series dealing with major problems in internal medicine. It is a mercifully brief presentation of the state of the art in the fast moving field of viral hepatitis, the 400 or so selected references updating us to 1977. One might note that the field would have moved much more rapidly if only we had managed to grow hepatitis A or B viruses in cell culture. As it is, we rely on people or expensive primates for much of our basic knowledge, and even for our vaccine antigens. Even so, it seems likely that within five years hepatitis B infections (in developed countries) will have been controlled by vaccination. In the book, separate chapters are devoted to aetiology and pathogenesis, epidemiology, prevention, and to acute, fulminant, and chronic hepatitis. Non A non B hepatitis receives mention, and hepatic coma is discussed. There are many excellent tables and diagrams to illustrate the text, and some histopathological figures, not all of which are so impressive. The virology is well presented, and an interesting chapter on extrahepatic manifestations deals mostly with the immune complex phenomena and with hepatoma associated with hepatitis B infection.

In giving us this balanced, reliable account of such a complex field in such a short space the authors have revealed their own long experience and good judgement.

C. A. MIMS.

"Review of Short Forms of the M.M.P.I." by T. S. Faschingbaeur and C. S. Newmark. Pp. 188. Price £12.00. Published by Lexington 1978.

The Minnesota Multiphasic Personality Inventory (MMPI) appeared in 1940 and has been used in a vast mass of research, chiefly in North America. It consists of 550 affirmative statements to which the subject responds with "true", "false", or "cannot say". This amounts to a very long test whose length is a serious disadvantage in many clinical situations. Hence these authors (as well as some other psychologists) have devised shorter forms of the MMPI. This book gives a mass of technical information about the psychometric properties of these shorter tests. It is likely that only a person contemplating the use of a short personality test is likely to even think of referring to this book.

J. P. WATSON.

"An Atlas of Radiological Anatomy" by J. Weir and P. Abrahams. Pp. 285. Price £15.00. Published by Pitman Medical 1978.

This is a beautifully produced book that is a pleasure to look at. Although by no means a comprehensive atlas the authors have covered most of the common plain film and contrast studies and some less common ones. Each two page spread consists of an X-ray plate or plates on one page with a negative line drawing on the opposite (i.e. white outline on black background).

This presentation of line diagram is very effective and corresponds well with the X-ray negative. A short comment accompanies each film summarising the principle indications for the particular projection or contrast study.

Some sections are better than others. the film of cerebral arteriograms and venograms are particularly impressive. A little diagrammatic licence would have enhanced some of the plates. Particularly the hilar structures of the chest and the vascular pattern of the kidney and pancreas. The only films of the anterior descending coronary artery failed to show the important terminal few centimetres as it curls around the cardiac apex. A most useful feature when trying to differentiate the diagonal branch from the anterior descending, this is not just an academic quibble but of great importance in assessment of patients for coronary artery by-pass grafting.

Perhaps the major criticism is that much more could have been included if some of the films and more so some of the diagrams had been reduced in size. One feels a sense of extravagance similar to that experienced in purchasing those large glossy art books usually seen gracing the shelves of the materially well to do. This criticism is I feel outweighed by the pleasure of seeing so many good quality radiological demonstrations of human anatomy.

A. J. S. SAUNDERS.

"Structure and Function in Man" by S. W. Jacob, C. A. Francome, and W. J. Lossow. 4th Edition. Pp. 678. Price £10.00. Published by Saunders 1978.

Stanley Jacob is a professor of surgery, Walter Lossow a non-medical lecturer in physiology and anatomy, and Clarice Francome a medical illustrator. The volume is profusely illustrated, with a judicious use of colour. The illustrations are in general accurate and pleasing, and they provide in themselves an excellent introduction to "structure and (to some degree) to function". The text is very clear; each chapter begins with a set of objectives—a fashionable slant; but each objective is capable of interpretation at such simple or complex levels that little is effected by stating them. A useful summary follows each chapter. The general tone is perhaps somewhat too clinical, which will appeal to many. Anatomy is not treated as a subject capable of intellectual attention and the physiology is well-skimmed of all but the clinically relevant. Two whole pages are wasted in cataloguing the skeleton, while the thorax is still a mere "bony cage" to support and protect—respiration is not mentioned. In fact, the skeleton at large is only belatedly recognised as an essential component of the locomotor system. It is a pity that a book so well-conceived and so well illustrated should lack enlightenment regarding function at the macroscopic level. Muscles are quite beautifully illustrated, but functions are relegated to tables of brief remarks; there is no attempt to deal with the combined actions of muscles in, for example, hand movements, walking, etc. Altogether a book of mixed excellence and weaknesses.

R. WARWICK.

"Anatomy of the Human Body" by W. D. Gardner and W. A. Osburn. 3rd Edition. Pp. 563. Price £10.50. Published by Saunders 1978.

This relatively small book, which is also reasonably priced, is a veritable *multum in parvo*. It not only covers the

whole of topographical anatomy in acceptable detail, but also includes simple sections on cytology, histology, and embryology. Each section is also followed by a series of review questions, and the entire contents are summarised at the end of the volume as a series of "learning units". The book is naturally orientated towards clinical medicine, as it should be (the senior author describes himself as a physician-anatomist); but this is not done obsessively, and normal function is pleasantly grafted into many parts of the text. The illustrator (Osburn) has provided a plethora of simple but most effective diagrams, which are very numerous. Provided he is prepared to go to other books the medical student will find this new edition an even more useful introduction than its predecessor; and it is perhaps even more appropriate to those with less demanding needs in paramedical fields.

R. WARWICK.

"Therapeutic Recreation Service: principles and practices" by Richard Kraus. Ed. D. Pp. 395 illustrated. £10.00 (hard back). Published by Saunders, 1978.

This is the second edition of a book published in and, in practice, relevant to North America. As such, it abounds with words like "deinstitutionalizing" and "meaningful" terms like "mainstreaming the disabled" but, once adjusted, one reads on to discover the existence of a hierachy of therapeutic recreationists ranging from assistant via technician, leader and specialist to a Master Therapeutic Recreation Specialist. The author estimates that there are some 16,000 in the United States, and that the U.S. and Canada between them provide 95 courses leading to bachelor's and/or master's degrees.

Recreational therapy—practised in hospitals, institutions, special schools, prisons, and the Community—is linked with the more familiar occupational and physical therapies as a form of activity therapy and with the rather less recognisable entities of bibliotherapy and remotivation therapy. The author insists that his colleagues must work knowledgeably and cooperatively as part of a rehabilitation team, and be accepted by it. He does, however, admit that, even in N. America, "recognition is still on a somewhat tenuous basis".

It would appear that this variation on the therapeutic model is a cross between remedial gymnast, play organiser and diversional therapist but the scope appears to be limitless. It can well be understood that such an individual could contribute greatly to the alleviation of boredom of those penned up in one institution or the other, and the greater development of those in some way handicapped, but it is improbable that the P.T.A. Whitley Council or the Council for Professions Supplementary to Medicine will be troubled by the question of their inclusion as yet.

R. J. COOPER.

"Atlas of Neonatal Histopathology" by Moragas, Ballabriga and Vidal. pp 238. Price £43.75. Published by Saunders, 1978.

This colour atlas, from the University of Barcelona is based on material taken from more than 3,000 autopsies over a 7 years period.

While some of the photographs are good and illustrate a variety of techniques, many are of poor quality and do more to confuse than to illustrate a particular point. Where a condition has a number of different names, these have not been referred to and this I feel is important in a book, translated with a view to wider circulation. There is a failure to define, even briefly, many conditions with obscure terminology and no indication as to whether a particular lesion is common, rare, etc. A list of references, even a short one, would add greatly to the value of the text.

However, the idea of clinico-pathological correlation, which this book sets out to achieve, is a good one, making it of value both to paediatricians and to general pathologists confronted with problems unique to the neonatal period.

JULIET HEATON.

"Encyclopedia and Dictionary of Medicine, Nursing and Allied Health". Benjamin F. Miller and Claire Brackman Keane. Pub. Saunders. Pp. 1148. Price: Indexed £11.25; Plain £9.25. 1978.

The objective of the two authors (a doctor and a nurse) has been to provide a vocabulary for "students of all ages and degrees in the nursing and paramedical sciences". In this they have succeeded, with numerous, well written articles on subjects which range from burns and pneumonia to cerebro-vascular accidents and rehabilitation. It is no mean achievement to describe the anatomy, the functions and the main pathological conditions of the liver in just over a page, but within the limitations which this imposes, the job has been admirably done.

A book which runs to a second edition has the hallmark of success. The text has been expanded to include such developments as problem orientated medical records, diagnostic ultrasound and computer assisted tomography. There are also numerous good illustrations, which are concerned mainly with simple anatomy and with medical and nursing procedures. Patient education receives some emphasis, and no doubt many copies of the book will find their way onto the family bookshelf. (What the family will make of some of the more complex tables on the origin and insertion of muscles and the distribution of arteries and nerves is another matter!)

All in all, a successful publication.

M. H. LESSOF.

"A Primer of Medicine", by M. H. Pappworth. Pp. 438. £7.95. Published by Butterworths, 1978.

There is something rather sad about the way the Mods and Rockers of the fifties eventually settled into their suburban semis and raised a noisy family "just like everybody else". More evidence, if any is needed, that the young rebels of one generation turn into the establishment figures of the next; but I never thought it would happen to Dr. Pappworth, one-time scourge of the M.R.C.P. examiners.

Dr. Pappworth's "Primer of Medicine" is mainly concerned with bedside method and diagnosis. It is now in its fourth edition. He writes as he talks, in phrases that may not be profound but are certainly memorable. "There are three causes of a triangular face, namely congenital hydrocephalus, Paget's disease and achondroplasia." The book is full of advice—on the way to take a history, the choice of a stethoscope, the method for eliciting a knee jerk, or on the differential diagnosis of short stature. But no investigations or tests—first, because the bedside method is paramount, and also because investigations already receive too much emphasis from those who teach medicine. Perhaps that is a point which should be well taken.

Only a popular book runs to four editions. Part of this popularity may well come from the frequent sideswipes at authority which the author cannot resist. Auscultators who are "persistent fakers or sufferers from auditory hallucinations . . . too often become consultant cardiologists, infecting their students with the malignant game of guessing." And so it goes on. All good clean fun!

Conventional attitudes certainly need to be shaken up from time to time. Even where his points are made by exaggeration or caricature, it is refreshing for the reader to consider where the cap fits. This author has not only influenced medical teaching but, by sponsoring Ethical Committees, has also influenced the larger field of medical practice. Students should certainly read this book —as long as it is not the only book they read!

M. H. LESSOF.

Current Therapy 1978. Ed. H. F. Conn. Pp. 947. £18.00. Published by Saunders, 1978.

This well established compendium consists of a large series of very comprehensive articles. The list of contributors and their achievements cover twenty double column pages, and the result (as with the previous editions) is a very successful and rather encyclopaedic work.

The main emphasis is a practical one, with an outline of the general principles of management, followed by advice on what the practising physician should do. Some of the emphasis seems strange to the English doctor. Topically active corticosteroid aerosols are "now available in the United States" while "salbutamol has been used with success abroad". Such comments serve as a reminder of the restrictive effect which the Food and Drug Administration now has on American medicine.

It is intriguing to find an unusually lengthy and detailed article on the surgical management of atherosclerotic disease of the aorta. Here is a very active (or aggressive?) approach to cardiovascular disease and also a surprising degree of detail concerning anaesthetic requirements and operative technique. The article is, in fact, less incongruous than it sounds and offers a painless way of improving the physician's education in surgical matters.

All in all, a sound book, which is particularly likely to find favour among libraries and as a reference manual.

M. H. LESSOF.

1. **"Diagnostic E.N.T." by G. D. L. Smyth (Oxford Medical Pub.). Pp. 138. Price £3.00.**
2. **"Fundamentals of Otolarynology" by Adams, Boies and Paparelia. £12.50. Published by Saunders.**
3. **"Hearing and Deafness" by Hallowell and S. R. Silverman. Pp. 552. Price £11.00. Published by Halt Rinehart.**

Mr. Smith's book *Diagnostic ENT* I really wish I had written myself. For a long time I have felt that our students and junior doctors required a book approaching the problems they have to face from the point of view of the symptom. It is "earache" or "deafness" that presents and that has to be disentangled and not "otitis media" and "otosclerosis". The book is clearly and simply written by one of our most distinguished surgeons and that in itself I consider to be an important recommendation. It is the real expert among us who is the most entitled to write the simplest book. I have no doubt that it is this paperback which, at £3.00, will find its place in the pockets of our students and will be quickly consulted by our House Surgeons and Casualty Officers as they are called to see a patient with "dizziness" or with a "running ear".

Otolaryngology is a relative small speciality and it is somewhat overwhelming for the specialist with academic pretensions to find himself showered by requests for contributions to edited books, to write books of his own and then to receive volumes, literally by the dozen, to review. The question must arise regarding the need for all this. To some extent the answer is negative. Perhaps there is a place for a large, highly comprehensive edited reference book in many volumes and then a series of monographs, necessarily small, written by specialists in a particular field which they know well and where they feel more free to present their own outlook than in the uniformity of a book by numerous authors. Books like *Fundamentals of otolarynology* by Adams, Boies and Paparella fall in between and it is difficult to know who to recommend it to. It is fine, well-written and up-to-date, well produced and clearly illustrated. By today's standards at £12.50 it is not unduly expensive, and yet containing clearly more than we can ask our students to read. For those who wish to look up a particular point or who are studying for higher qualifications it probably does not offer enough. It is an American book and possibly finds a place somewhere in their scheme of training. I hope so as it is a good book and I wish I could put it somewhere other than the bookshelf.

The third book I have received, *Hearing and Deafness* is edited by the true doyen of audiology, Hallowell Davis, and it is a pleasure to find that he has personally written a major part. The few individuals of that calibre who are able to continue working to a great age offer a general outlook and profound knowledge that others cannot achieve. Richard Silverman, the other editor, has also no mean reputation. Obviously this book is not intended as routine reading for medical students but it will be just the type of reference work which anyone connected with the deaf and their management will want to consult.

ELLIS E. DOUEK.

"Grey Scale Ultrasound—A Manual for Physicians and Technical Personnel", by Bartram and Crowe. Pp. 216. Price £10.00. Published by Saunders.

Grey scale Ultrasound scanning is a relatively new addition to our diagnostic armamentarium. Because of this, there is little in the way of literature relating to it although this is increasing in amount rapidly. This new manual provides a welcome and refreshing approach to the subject. It is aimed initially at those who are starting to scan and who are in a process of developing an Ultrasound service. Many of the experiences related by the authors corroborate our findings during the last three years whilst Ultrasound service has been built up. Most of the texts so far available make light of the difficulties encountered whilst gaining experience. The authors of this book describe in a readable and informal style how they have overcome the problems which a new technique presents. Much of the book therefore is directed to those who are actively engaged in scanning but the chapters devoted to descriptions of scanning of various areas should be extremely helpful to those who are referring patients to the Ultrasound Department.

Much of the text is standard to those who have been following the rapid proliferation of articles on scanning technique and findings but it is useful to have all this between the covers of a single volume. The authors are American and their approach differs a little from those of their British counterparts. For instance, they reckon that nine patients per day, per scanning room is the maximum which they can scan adequately. In this country we do nine patients in a session and obstetric patients are scanned at approximately twice this rate.

However, the book can be highly recommended to those who are starting Ultrasound scanning and is valuable to those who are presently engaged in it. At £10.00 it is extremely good value.

BARBARA C. KING,

"Atlas of Echocardiography", by E. E. Salcedo. Pp. 236. Price £10.50. Published by Saunders, 1978.

This is a compact collection of echocardiograms of most of the commonly occurring heart conditions which are accessible to this method of diagnosis. The text is brief, in fact the first chapter on anatomy is too brief. The chapter explaining the technique of obtaining an echocardiogram is well presented and covers most of the possibilities offered by M mode echocardiography. The strength of the book lies in the collection of actual records. These are of high quality and enough examples of each condition are shown to cover most of the variations encountered. The text and the legends to the figures give a concise account of the conditions which are illustrated. The references are extensive if not comprehensive. The shortcomings of the book are that brevity has led to some uncritical statements. The statement that left ventricular volume can be calculated from the M mode echocardiogram should, if made at all, be qualified by another to the effect that this method is too inaccurate to be of use. Certain difficulties are somewhat glossed over, for instance that of differentiating fibrous thickening of a valve from calcification and from valvular vegetations. However, the biggest defect is that the section on congenital heart disease is totally inadequate considering the real strides that have been made recently in this field.

On the whole this is a useful book and should find its way onto the shelves of all departments using the technique but it does fall between being a totally comprehensive atlas and a brief introduction to the technique.

MICHAEL TYNAN,

Human Embryology, by M. J. T. Fitz-Gerald. Pp. 205. Harper Row Inc. Price $15.00.

This is a relatively short book with only 179 pages of well printed text and 163 black and white illustrations most of which are line drawings easily followed and reproduced. There is also a number of pictures of appropriate embryological sections. The scheme of the book is based on regional anatomy and it is therefore admirably suited for wedding the embryology to the part which is currently being dissected.

The book covers the morphological aspects of embryology almost entirely and there are few references to the experimental side of the subject. In terms of the demands made of medical students in their B.M.S. course this is no great loss because this is what they are expected to know and what is usually covered in their lectures. Each chapter of this book has a list of further reading and any student who wishes to read more about the subject can do so.

I particularly liked the chapter on the head and neck especially the part on the development of the brain and skull. The description has been oversimplified but it is easy to follow and the drawings are particularly useful. In the chapter on the abdominal and pelvic organs, the transformation of the vitelline and umbilical veins and the formation of the inferior vena cava are dealt with in a way which makes a difficult subject much easier to follow. Similarly learning about the development of the heart appears to be made much easier.

Somewhat unexpectedly there is a most useful "glossary of embryologic terms". One notices the Americanisms throughout the text and although the author's background and present residence are Irish he has spent a considerable time teaching in the United States. In addition the publishers are I believe American in the first instance. However if one reacts unfavourably to some of the spelling these feelings are mitigated by three apt quotations, one from Yeats, one from Joyce and rather surprisingly one from the author himself. Modesty might have precluded his quoting his own poetic efforts. However the quotation is apt and amusing.

As can be gathered from this review, this book is strongly recommended for what it is intended to be, "a straightforward account of human development" and a "primary source of information to students approaching the subject for the first time".

J. JOSEPH.

CORRESPONDENCE

Guy's Sport

Sir,

I wrote to the *Gazette* some years ago regarding the standard of reports and commentary in the Sports News and I am sorry to have to return to the same theme.

In common I suspect with many Guy's men past I found it quite nauseating to read in the September issue of the Gazette that the cricket side went on tour with only ten men and lost the first game of the tour to Bognor by 83 runs—a feat of which the reporter seemed to be inordinately proud. In the same issue we were informed that the Golf Society arrived to play the Consultants at Huntercombe late and short and consequently lost 8½—1½—again the writer seemed pretty pleased with that. It is surely only basic courtesy to the opposition to arrive for any match on time and with a full team.

Reports of this nature do nothing to enhance the reputation of the hospital's sporting prowess and they only serve to offend the many people who in the past have been proud to give sporting service to a (once) great sporting hospital.

If we are to be subjected to this type of poor humour I think most people would prefer the Sports Report to be omitted from the *Gazette*.

In the same issue of the *Gazette* it was refreshing to see a letter from Tony Cahill regarding the now defunct Guy's/Cuckfield cricket match which reminded many I am sure of the days when Guy's men arrived on time and usually left long after the opposition had retired.

Yours faithfully,

IAN REEKIE.

Mann Cottage,
Moreton-in-Marsh, Gloucestershire.

From Professor Haslewood

Sir,

A great deal has been said in the *Gazette* and elsewhere about the poor state of the National Health Service; indeed some have suggested that the N.H.S., like poor old Britain, is on its last legs and must be expected to collapse quite soon.

Well Sir, Britain has been going to the dogs in all my politically conscious memory, that is for 50 years at least, and perhaps your readers would be interested in a patient's comparison between the N.H.S. at Guy's now and about thirty years ago.

At the end of 1949, I was admitted to Addison Ward under the late Dr. Douthwaite for persistent duodenal bleeding and told by him that unless I had surgery for the ulcer I would surely die. Accordingly, the late Mr. Grant-Massie operated in January 1950: I had peritonitis and paralytic ileus and remained in Job Ward until March. At that time, Guy's was famous for some of its most devoted and formidable Sisters. Job Ward, then reached from the Colonnade, was part of the oldest Guy's and was beautifully proportioned, light and airy in a style we have hardly bettered even today; Addison was what it is now, high, gloomy and redeemed only by the nursing and other staff. Job had the renowned Sister Falwasser, probably the best-loved and most respected Sister of her time: she was totally dedicated to nursing and it wasn't until you were really ill that you realised what a gentle and loving person she really was; the patients knew, as in my experience men always sense which nurses care most, whatever their looks may be. Another famous night Sister was known as Auntie and I personally saw her overcome and board up a rough patient who had been brought into Addison off the streets during a cold December night: he only wanted to die and did so before the morning.

After about fourteen weeks in Guy's, I wrote to the *Gazette*, trying to express my deep gratitude for all the care and kindness I had received as a patient; indeed this experience made me fully realise for the first time what a wonderful place it is.

Now in February this year I was admitted to William Gull Ward with jaundice and was thoroughly investigated there by Professor Dowling, Dr. Sladen, and Dr. Goodship; later I spent twenty-four hours in Professor Keen's Metabolic Ward. In August, Mr. Maynard did a cholecystectomy and I was cared for by him, Mr. Payne and Dr. St John Collier in Luke Ward.

Once again I am filled with gratitude for all the skill and kindness shown to me and write to tell you that I could find no falling off whatever in the standards of medical, surgical, nursing or ancilliary care as between 1949 and 1978. In many ways, especially techni-

cally (blood sampling, drips, X-rays), methods are understandably much better. I was greatly impressed above all by two things: discipline and care for the patient. Discipline was very obvious; it was always perfectly clear who was carrying the can in the medical, surgical and nursing teams and that is most comforting to the patient, who feels he is in the hands of a highly trained group of people responsible to a chief with a strong sense of personal responsibility. The second feature, care for the patient, was overwhelmingly present; I have never heard so many "loves", "dears", "duckies" and other terms of affection in every corner of Guy's, from Wards to X-ray and from every grade of staff. I myself was rescued from one of those humiliating crises that occur after abdominal surgery by the Ward maid on Luke, a splendid lady called Lil, who put her strong arm round me saying "Never mind, love, I'm used to this sort of thing". The nursing was, as it had been in 1949-50, quite wonderful and the Sisters (what a comforting word that is, Sister) just as tough though perhaps not quite so formidable. I particularly recall the night Sister on William Gull, who demanded to know why I had slung my dressing-gown across the window. When I replied that it was to keep out the lights from Nuffield she snorted and said. "I'll soon get them put out: anyway don't you know there are a lot of private patients and foreigners in there?" When I remarked that even private patients and foreigners had a right to be ill, she said "but not to keep *my* patients awake" and got the lights put out. (The next time I visited William Gull, proper window curtains had been put up.) It was to me profoundly moving to watch these smartly dressed, bright, usually pretty and most efficient young women truly bringing tender loving care to their patients.

I thought, again, what a noble and wonderful place Guy's is and feel that perhaps the N.H.S. will last a little longer. Judging, too, from the stoicism of the other patients I met, particularly three young girls in the Metabolic Ward who all had horrible hormonal diseases and were facing their dark futures with the greatest philosophy and courage, it seems possible that Britain itself may survive for another fifty years.

Yours faithfully,

G. A. D. HASLEWOOD.

28 Old Fort Road,
Shoreham-by-Sea,
Sussex.

Third World Comment

Sir,

I have just received my July edition of the *Gazette* in which you are bemoaning the fact that Guy's has not spent £270,000 on an EMI Scanner whereas St. Thomas's have theirs installed and working. Is it so necessary that every hospital spends this amount of money on a machine?

I am one of a team working C.C. in a Health Centre here in Sierra Leone. Here babies die of neonatal tetanus because of the belief that a mud and leaf dressing should be applied to the umbilical cord at birth. Toddlers die of measles because of malnutrition; in fact 30% of the children under five are malnourished. Mothers die in childbirth because of a lack of ante-natal care and the belief that "granny" knows what she is doing when it comes to delivering babies—simply because she has had eight or nine children. It is a typical story which you can find in any developing country and we are trying to improve the quality of life by education and preventive medicine.

In this situation I read about hospitals and their £270,000 scanners (that money incidentally would pay my drug bills for the next eighteen years!). I'm not saying that we want a scanner here—far from it—nor am I saying that it is wrong for hospitals in the "developed world" to have scanners but I was thinking that this was only one more example of the gulf between the western world and the third world, the rich becoming richer and the poor becoming poorer. So the next time you spend £1,000s on a machine to benefit a few people just spare a thought for the people here and what we would do with £50! Maybe in the next *Gazette* I will read of Guy's, King's and St. Thomas's *sharing* their two scanners—or is that too much to hope for in the selfish western world.

Yours faithfully,

MISS S. LOMAN.

P.O. Box 78, Jaiama,
Via Kordu, Sierra Leone.

Annual Dental Clinical Day

Sir,

This is an early confirmation that Clinical Day will be held next year as usual on the first Saturday in March. I am glad to say that it will not be necessary to make a charge for those attending.

In the evening a combined Dental Dinner and the Dental Ball will be held in Grosvenor House Hotel, and it is hoped as last year, to maintain the traditional format of both functions in this one annual occasion. It will be open to all and not restricted to members of the profession, but Guy's graduates will be able to sit close to their contemporaries during the dinner.

Yours faithfully,

R. D. EMSLIE,
Dean of Dental Studies.

Medical and Dental Schools,
Guy's Hospital, SE1 9RT.

Sir,

It was with shock, dismay, and outrage that I read your report on the Dry Fly Fishing Club's first outing. How such libellous pap can be printed in a respectable journal, such as yours, is beyond my comprehension. To suggest that I wormed my fly not only besmirches my name, but insults the whole of the upstream fly brethren. Regarding this business of a garden spade—it is common knowledge that I have a passing interest in mycology —and at the time I was merely digging for truffles (unfortunately unsuccessfully —in contrast to my results otherwise).

Initially I was of a mind to demand an apology from your correspondent, the "anonymous" Mr. M.D., but after discussing the matter with my captain—who said that we might all be hoisted by our own petard, or words to that effect—I will let the matter lie. Quite what was meant by Adrian's cryptic remark I'm not sure.

Yours faithfully,

"DIRTY" DICK READING.

Battersea,
London.

Sir,

May I point out two glaring mistakes allowed to pass under the noses of the proof-readers in the last edition of the *Gazette* in the article "Where have the doctors gone—a student replies".

The second paragraph, 11th line down should read ". . . on the other hand, the necessity of taking the Conjoint exam as a safeguard rather suggests an 'expected disaster' in the MB exam".

The second error appears in the 4th paragraph, 17th line down, for "entail" as printed read "curtail".

Both mistakes make nonsense of the intended thought conveyed to the reader.

Yours faithfully,

WESLEY SCOTT-SMITH.

c/o Boland House,
Guy's Hospital,
SE1 9QT.

(*My apologies to Wesley Scott-Smith* —*Ed.*)

SPORT

SPORTS REPORT

Welcome to the first sports edition of the *Gazette*. We have tried to include all sorts of sport and make this a bumper issue. If your sport isn't reported here, why not? In fact we have had an excellent response from our sporting correspondents with more reports and write-ups than in any previous *Gazette*. Many thanks to all who have contributed, especially Jon Beard who has put in a great deal of work at very short notice.

This is also the first full edition seen by this year's Freshers — welcome to them all. I usually try to give a few hints for those not in a team at this stage of the sporting season about various methods of achieving a place. However, I have just slithered through two teams myself and don't feel well qualified to do so at present. I will say that with consistent effort (and a dash of cunning) you will achieve your ambitions. A man riding high with success at the moment is Gary Calver, now stalwart at the heart of the solid defence of Guy's second soccer team. He has been enthusiastic on the sidelines of this team for the past three years and now deservedly has his own place. About a year ago I tried to get a sportsperson of the month award going which failed due to apathy (not mine). Gary is definitely sportsman of this month—keep biting those legs, Gary! If anyone knows of someone deserving of a mention please drop me a line at Boland House.

I wonder if any ladies read sports reports? I hope one or two of you do. I can't remember ever having a report about a ladies' sporting club. There is so much for ladies to do at Guy's that it is very disappointing that they don't do more. Here at the hospital there are free squash courts to be booked next to the York Clinic, a nurses' tennis court which can be used by students and the Pavy Gym for badminton, weight lifting and anything else you care to do. There is a rowing club based at Chiswick and Guy's playing fields at Honor Oak Park with tennis courts, five hockey pitches with a ladies' hockey team and an all-weather playing area which could be used for volleyball, lacrosse (I think) and netball. So ladies, wake up! Why should you go on subsidising the sport of us fella's with your Clubs' Union membership fee if you don't take advantage of the facilities provided. If you don't agree with me let's hear from you and tell us all what you do in your spare time.

Lastly, so many small clubs seem to be taking off in a big way. Good luck to them. The dry fly fishers' club is one such team. However, after reading about the exploits of "dirty" Dick I was rather shocked to hear that the roving dry fly reporter M.D. (pseudonym) himself was seen entertaining the available Lady Jane Finsley in a posh restaurant in town recently. I gather there was some sort of fracas when the bill arrived, which ended with Lady Jane covered in pink champagne and a head waiter with a black eye due to the old Finsley right hook. Apparently M.D. had visited the "gents" where a window was found open ten minutes later and his Mercedes was gone. What complicated lives these upper class people live. I hope M.D. will have recovered in time for next month's instalment.

JONATHAN EARNSHAW.

RUGBY

Cheltenham 23 pts., Guy's 6 pts.

The resumption of this fixture, after a seven years lapse, saw Guy's into action earlier in the year than usual. In the period since the last game both sides have had their problems but the game began brightly, both sides running the ball from free kicks. In an even battle Guy's conceded a try just before half time to switch four points down. The strong Cheltenham pack denied the swifter Guy's backs the ball and managed to run in several tries. Guy's reply consisted of two excellent penalty kicks by a rejuvenated Martin Danford, but even this could not loosen Cheltenham's grip up front. It was disappointing to travel all the distance to Cheltenham and not really show our paces but perhaps it took too long to convince our team the season had really begun.

Team: Parry, Gibson, Neill, Keevil, Beard, Brazier, Robertson, Loxton, Mant, Broughton, Portelly, Emery, Wilkinson, Francis, Danford.

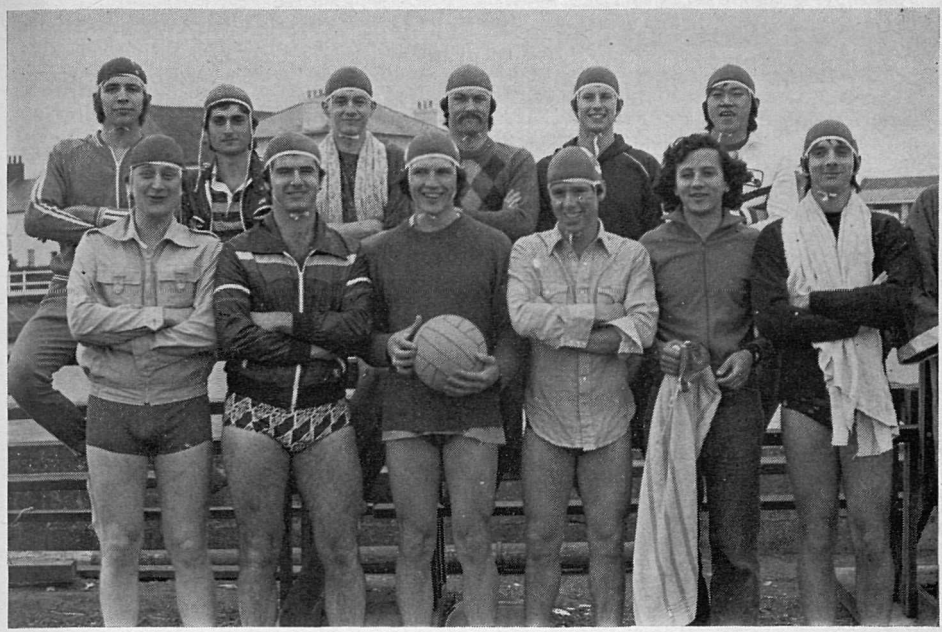
Guy's 10 pts., Blackheath 15 pts.

Both clubs have had their ups and downs recently, but some determined early work by the Guy's forwards gave Guy's the initiative to score twice in the first half. Former captain, Graham Francis, nipping in near the touchline after a good interpassing movement, and Mike Broughton capitalising on the pressure Guy's were exerting at centre to score near the posts. Francis converted. Blackheath's reply consisted of a converted try by Williamson and a drop goal from a free kick which caught the Guy's defence napping. Leading 10—9 at half time, and with the wind in Guy's favour a sensational upset seemed possible but Blackheath scored what turned out to be the winning try after a burst close to the scrum by their scrum-half Hartley. This still left Guy's within a goal of victory but the gaps in the Blackheath defence were plugged, sometimes desperately, by full back Williamson. Guy's, although defeated, can take great credit in this performance which showed that when the majority of the team come on song together Guy's can still be a threat to any side. The lineout work was excellent, the back-row covered well and harried the opposition enthusiastically, the backs looked good in attack and defence, Mike Broughton making some outstanding breaks. Significantly too, there was a positive, disciplined spirit in Guy's play which kept Blackheath out even in a succession of five yard scrums. It was gratifying, in the aftermatch celebrations, to be told by the opposing skipper that for once Blackheath, not Guy's, had all the problems.

Team: Parry, Gibson, Neill, Beard, Keevil, Mihill, Brazier, Loxton, Mant, Broughton, Emery, Wilkinson, Portelly, Francis, Moore.

WATER POLO TOUR 1978

This year's tour had the highest attendance ever—12 people (players ?) in all. This phenomenal number may have been due to the fact that this year we borrowed the Boat Club minibus which enabled us to all travel together rather



Water Polo Team

Back row, l. to r.: Jon Beard; Mark Vella; Pete Robinson; Andy Smith; Dave Rickard; Gabriel Teo.

Front row, l. to r.: John Taylor; Raymond Aquilina; Mike Miller (capt.); Andy White; Sant Khan; Mike Miller.

than split up in several cars as has been usual. The other reason for the large number may have been the temptation of a large tour fund which withstood the onslaught upon it very well.

As usual the tour was of the South Coast with the only change of fixture being Hythe instead of Salisbury (perhaps they are sore because we beat them for the first time last year?). On Friday evening we arrived at Yeovil, with the minibus still in one piece, and were then beaten as usual 8—3. Having accepted our usual fate at Yeovil we gladly accepted the club's hospitality followed by the ritual take away Chinese meal which was devoured as silently as a Chinese meal for twelve can be in the bedrooms of our (bed and breakfast) accommodation.

The following Saturday morning found us shivering miserably at the side of Bridport harbour whilst the opposing team cheerfully informed us that the water was colder than last year. Having discovered that the only way to get into the water was to throw each other in, we proceeded to beat Bridport 8—3. This was probably because we had enough players to replace those who froze up.

On Saturday evening we played Hythe, having spent the afternoon eating strawberries and cream whilst Andy White and Gabriel Teo made eyes at the little girls who were playing in the garden of the restaurant at which we were staying. Hythe were a very weak side, having only just formed and we beat them

easily 25—2. The two Hythe goals were also scored by our players thanks to their accurate back flicks to the goalie.

On Sunday morning we played Bournemouth, after enduring a ladies' water polo match beforehand. This match was the most closely fought of the tour, and we narrowly lost 6—5 due to some careless play in the last quarter.

The journey back to Guy's was uneventful apart from a stop-off in the New Forest to play football. Our thanks to the Boat Club for the use of their minibus which gave no trouble at all, apart from its dangerous tendency to veer to the wrong side of the road on braking, and the total lack of braking power.

JON BEARD.

SOCCER

The end of last season saw Guy's 1st XI being promoted to the premier division, and the second's being promoted to division 2R by topping 3R and also reaching the UH reserve cup final. This year has seen the 3rd XI established into division 4R and appear competent to justify their inclusion in the league. It is to be hoped that the success of last season will be continued this year. Several Freshers have gained places in the seconds and thirds and shown good promise for the future. Good luck to them!

Guy's 1st XI 2 v. UCH 3. 11th October

The opening match for the 1st XI took place away to UCH on a warm sunny Saturday at Shenley. The game began after a slight delay following attempts by the majority of the team to travel the A1 from one end to the other before reaching the ground. It unfolded as a game of few chances and as far as Guy's were concerned, many mishaps.

Both teams started nervously and appeared to be fairly evenly matched until after fifteen minutes when the deadlock was broken when Ken Harper kicked the ball onto the legs of keeper Nick Cowland in a vain attempt to clear the ball from defence and both were left watching the ball trickle agonisingly into the goal. Guy's fought back well and were rewarded in the twenty-fifth minute with a penalty for hand ball by a UCH defender following a corner by Simon Perkins. The penalty was successfully converted by Paul Sheppard, the first league goal of the season. Half time arrived with the score still 1—1 and Guy's were hopeful for better things in the second half.

After five minutes of the second half an unlucky own goal by Neil MacLachlan resulted in Guy's going behind again, 2—1. The equaliser came after fifteen minutes from Mike Breeze, a well placed header from a free kick by Simon Perkins. There then followed a period where the Guy's defence faced a lot of pressure and the UCH defence were posed few problems by the Guy's attack. After twenty-five minutes a dubious offside call left three UCH attackers free and they seized on the chance to go 3—2 ahead. The remainder of the game showed very little promise, neither team really showing any sign of scoring. An unlucky game overall for Guy's.

Team: Cowland, Rees, Harper, MacLachlan, Batterbury, Wilson, Perkins, Smalley, Breeze, Sheppard, Underwood.

K.H.

Guy's II 2 v. Bart's II 1. 11th October

The sun was shining brightly as Guy's second team took to the field for the first match of the season against their old enemies Bart's with whom they were promoted last season.

The team whilst retaining something of last season's flavour had a certain freshness about it. Robin "Rubber Man" Evans was in goal as ever but the back four consisted of our gallant vice-captain (or just vice?) Harry "Spider Man" Williams, Gary "Gentle Giant" Calver, Richard "Sorry I missed last season" Trembath and newcomer Phil Bearn and had a new look combining unfitness and *savoir faire* with a certain unsubtlety. The midfield was led by Captain Roger "Engine" Davies, Dave Greenaway and new boy Dominic Beer, combining industry, and sheer bloody mindedness. The revamped attack of John "Flyer" Rawcliffe, Jon "Ton Up" Earnshaw and Keith "The Kid" Underwood combining two left feet, one right foot and a certain rivalry. Missing from last year's regulars were Mark Batterbury called to higher things, Liam Broughton who hopes to be fit for the next match, injured Dave Abraham and Graeme Smith who was mysteriously indisposed on the eve of the match but was rumoured to be having a picnic somewhere near Oxford.

So with the above line up the team ran out into the sub-tropical heat. They played the ball around with style, ran about like lunatics and sweated a few gallons and then the referee arrived and we started the match.

The first ten minutes proved our

worst suspicions—Bart's wanted to win as well. The defence put under pressure began shakily but Rich Trembath organising from the back soon sorted it out, shouting well until his voice gave out.

Guy's then began to settle down with midfield gaining control and Davies going close with a couple of long range efforts. Guy's forced a couple of corners and then Keith Underwood took a corner on the left, Trembath, B.Sc., thinking about tactics again sent the Gentle Giant lumbering forward with a few well chosen words, "You go forward—I'm knackered". He came in on a late run, only to get there too early. He, two defenders and the goalkeeper missed it, Earnshaw headed it back in and from the melée Calver thrust a long unshapely leg forward and cracked a scorching volley into the net from all of three yards. His first league goal ever for Guy's in three seasons! For the remainder of the half, with Davies encouraging his troops Guy's contained Bart's threatened fight back. Our forwards combined well but were unable to penetrate Bart's steely defence. Half time came none too early and the oranges were greedily devoured.

Guy's began the second half in determined style. Phil Bearn deciding if he couldn't get the man he'd go for the ball. With Robin Evans playing solidly in goal and the defence standing firm Guy's became more adventurous. The attack foraged well with Keith Underwood shining on the right wing. Chances however still came only for Rawcliffe and Earnshaw to be denied by good work by the Bart's defence. Both sides were becoming tired by now but Bart's superior unfitness didn't give them the edge and their spirits sunk further when after good work on the right Underwood swung a cross over to Rawcliffe who beat his full back and sent a shot against the post which cannoned off the prostrate goalkeeper and into the net. Guy's were dominating at this stage but traffic wasn't all one way and Evans was beaten for the first time only for Phil Bearn to clear from the line. With minutes left one of the Bart's forwards pierced the defence where Calver, eager as ever and as fresh as a compost heap in October, went for the ball only see the Bart's forward dive over his outstretched leg. The referee commented "We don't do penalties on my course until next week, I'm glad it was an easy decision!

The Bart's number ten made it look easy, giving Evans no chance.

All in all a promising start to a new season in a higher division. "REVLAC".

Guy's II 6, Royal Holloway II 0

Two points from the first league fixture three days earlier gave the team an enthusiasm and confidence which was much in evidence for this meeting with Royal Holloway.

From the first whistle Guy's took command of the game, pushing the ball around with and probing the visitor's defence. John Rawcliffe pounced on some poor defensive work after ten minutes and after a good run put Guy's one up. Five minutes later Roger Davies sent Keith Underwood clear on the left and he took the opportunity well, scoring his first league goal of the season and increasing Guy's lead to 2—0. The forward line were posing great problems for the Holloway team, Graeme Smith making some fine runs on the right wing and it was from this side of the field that a ball was played to the penalty spot for John Rawcliffe to make it 3—0 at half-time.

This second half saw Guy's as determined as ever. The defence was solid with Phil Bearn safe, Gary Calver winning every ball in the air and Rich Trembath coolly covering everything in his controlled manner.

Up front John Rawcliffe completed a hat-trick to make it 4—0. After seventy minutes a superb build-up involving five players saw a low cross turned in by—yes John Rawcliffe for the goal of the match, unfortunately he injured himself in the process and missed the rest of the game. Dominique Beer and Dave Greenaway were controlling mid-field and even with ten men Guy's were still in command. Roger Davies hit the bar from thirty yards and Graeme Smith rounded off the afternoon by racing on to a through ball and calmly lobbing the goalkeeper to make it 6—0.

This was a well earned victory by the Guy's II team who showed that this season they are going to be fighting for promotion to Division I and must have an excellent chance of winning the U.H. Cup.

R. DAVIES.

3rd XI SOCCER

SHOCK: NOBBER NOBBLED!

Following pre-season preparations at a secret summer camp, somewhere near Burnley, the finalised plans of "Attack First, Defend Later" have formulated in a wave of precision, verve, and fluidity in Guy's Thirds first two league matches resulting in ten quite breathtaking goals. However, a lack of foresight, rebounds,

Guy's 2nd XI Soccer

Ten to one they'll have a great season.

miskicks and assorted mishaps have allowed the opposition to take twelve lucky goals.

Excitement and enjoyment has been seen by all although slightly marred by an incident which shook the football world on a scale similar to the Munich Air Disaster. The thirds' valiant "man between the sticks" Mark "Nobber" Billington received a tragic injury, a fracture of his primary digit, incurred during a brief melee in the first game. He carried on despite severe pain which could only be truly compared with Bert Trautmann's broken neck in the 1956 F.A. Cup Final. His understudy Nick Kendall carried on the good work in the next match although several fair shots did seem to pass him by.

The matches themselves were both see-saw affairs. The first, against Westminster II, ended in a 4—4 draw, both teams slowing down near the end (of the first half) due to slight problems with physical fitness. Against U.C.H. II lack of fitness again rather than lack of skill and determination resulted in a promising 5—2 lead dissolving into an ignominious 6—8 defeat despite a vibrant vocal haranguing by Skipper S. Nigel Robertson known in the middle of the park as little stopper and off it as the big man. (No matter how readers interpret the scoreline no tries were scored.) Thanks also must go to Jon Earnshaw for his four goals and Chris Thomas for his intrepid and unbiased (in a way) refereeing.

RALPH POTTS AND ALF STYLES.

HOCKEY REPORT

The Hockey Club this year appears to be flourishing with a pool of at least 30 players to call upon. The 1st team has been greatly strengthened by the appearance of some talented freshers including Chris Barris, Niaz Kanin, Andy Emmerson and Sukhpal Singh and also Clive Straker over from S. Africa as an elective.

The season began with a fine 5—2 victory over the 71st Lancets. Having gone down 2—0 in five minutes our youthful exuberance proved too much for the opposition and goals from Straker (2), Plowman (2) and Jones (1) were sufficient to secure victory.

Our next game was against U.C.H. at H.O.P. Having lost twice last season to them we were determined to gain revenge. For most of the game the defence was very tight with particularly aggressive play from Saward, Singh and Saunders and the forwards linked especially well resulting in an expensive hat-trick for Plowman with Gulamali and Straker also scoring fine goals to give us another well deserved 5—2 win.

The following fixture was our first league game against Woodstock and a welcome return of Pascoe in the goal-mouth. A somewhat dubious goal from Jones was enough to get 2 points but 1—0 was a rather disappointing score-line against a far less talented side than ourselves.

GOLF

The trouble with the Golf Club

For those who aren't aware, Guy's has a long established golf club whose activities over the last few years many would describe as punitive (many describe the sport that way), however, if I may be trumpeteer, we have been a quietly successful club.

Golfers may boast about prodigious feats on the course, the eighteen footer which hit the back of the hole and stayed out, and the time he was eight holes down with nine to play. These pearls are easily milked out of the average golfer when his frontal lobes are well oiled with good beer and he has an attentive audience! But, contrary to character, the club has been rather quiet about its activities.

We're not a band of elitists as, surely, anyone who's aimed iron and wood to rubber and plastic on a course is entitled to call himself a golfer, even if only once, and really the members of our club ought to be numbered by the ranks of such individuals.

There are several breeds of golfers to be seen; there's the one who, day after day, with unerring obsession and varying success will always be there perennial on the grass, spurred on to greater efforts by just one fleeting moment of glory, one 100 per cent shot, the pat on the back by partners and the well harrowed reminiscences over the inevitable drink, such small things making it worthwhile. There's another type, equally obsessive, the perfectionist, things are never good enough, always complaining about what he should have done, deliterious mutations will always occur.

And then there's the Guy's golfer! Average kind of chap, he likes a good time, a good game, but I'd like to think, someone who accepts victory and defeat with equanimity. The club is not out to produce Jack Nicklaus's but to bring together people who are just a little interested with those who are obsessed with it hopefully engendering a little club spirit. In this respect, the club has failed dismally and therefore deserves to some extent the label of élite, but this is not by choice. The solution seems so simple, I think all it needs is the name and address and telephone number of all Guy's golfers from whatever department so that a list may be circulated to each of you thus enabling people to arrange a few friendly holes much more easily so encouraging a source of "clubmanship".

Certainly, permanent fixtures, such as the ever popular consultants' match where quite a few different personalities engage in friendly competitive golf provide a good basis for the continuing of the club as a social and living thing where the killer instinct and incessant desire for crushing victory, which seems to be many people's idea of sport, is as out of place as "Dubonnet" in the Globe.

If interested please leave a message on extension 3232 or in the golf club pigeon hole in Boland House.

STUART MATTHEWS (Secretary).

MOUNTAINEERING

Yes, there are sheep in Iceland!

"Flight 2.30 p.m., so meet at bar, terminal two 12.00 a.m." so came the instructions from Paddington, the Bear, at Heathrow. "Please try to abide by customs regulations."

So in good Guy's tradition began a memorable expedition to Kjölur which resulted in the ascent on a previously unclimbed peak, and several new routes. The Kjölur district of central Iceland is a large plain (900 sq. miles) bordered by icecaps, mountains and hot springs. It lies about 150 miles from Reykjavik and is bisected by a rough road (!) linking the North and South of the island. To the East and West are, respectively, the ice-caps of Langjökull and Hofsjokull some thirty miles apart. The former presents steep icefalls and glaciers as well as the prominently glaciated Hnitfell (1,410 ft.) and the latter a far gentler profile towards the central plain. On the plain are extinct volcano craters, large rivers, lakes and hot springs. At the southern boundary of our expedition area is Kerlingarfjoll a moutainous area of peaks composed of strikingly colourful liparite, tufa and basalt. The volcanic

Conference of Maneating Sheep?

activity which built the mountains has left a legacy of fumaroles and hot springs. Indeed the conflict of cold arctic and hot volcanic conditions has produced beautiful, strange effects.

Although the expedition was undertaking ecological, biological, botanical, zoological, geographical and artistic work I was there for the mountaineering of these almost alpine mountains. We had undertaken in addition to survey a small glacier—which when we found it had disappeared (!). Unfortunately feeling very good hearted at this stage three of us decided instead to survey the main Blagnipa snout of the Hofsjokull glacier which had not been done since 1963—we soon found out why—so if you hear anyone exploding with the word "Blagnipa" you need no reassurance that he is cursing.

On The Kerlingarfjoll.

Once we'd finished this work we began the task that the Alpine Club had encouraged us to do, namely the exploration and quantification of the mountaineering prospects of central Iceland. If you want to know what we found you'll have to buy a guide book which we are writing. It was a mixture of hard work and great fun and a wonderful eye-opener. How many times have you had to ford a river with water of 3°C lapping around your navel, six times, 150 yards each time? It was much easier when a member of the party "found" a sort of Land Rover which seemed to have no owner, not to mention the 'bus which had been abandoned halfway up (or was it down) a steep hill—it was so much more comfortable than tents.

I even found some time to do some original work (yet to be published—Kjölur Archives of Certification) on the physical fitness and adaptability of the party to a harsh alien yet exciting environment. How did you guess?—yes, there were sheep—indeed Iceland has over a million, white, brown, black, grey and any other colour you care to dye them.

None of this would have been possible without Enid Paddington Smith, Megabladder Southall, Al Haggis Barclay, Henry Gertrude Clover, Ian Glendfiddich Johnson! and of course the sheep!

ST JOHN BJORRSON.

Left to right: *Dave Davies, Liam Hughes, "Sparky" Woods, Bob Dobson, André Hedger, Helen Herbert, Barbara Pilkington, Mary Illingworth, Meg Llewellyn-Smith, Chris Darby, Judith Tranter.*

Photo by Nicholas H. Taylor.

MOUNTAINEERING CLUB 1978

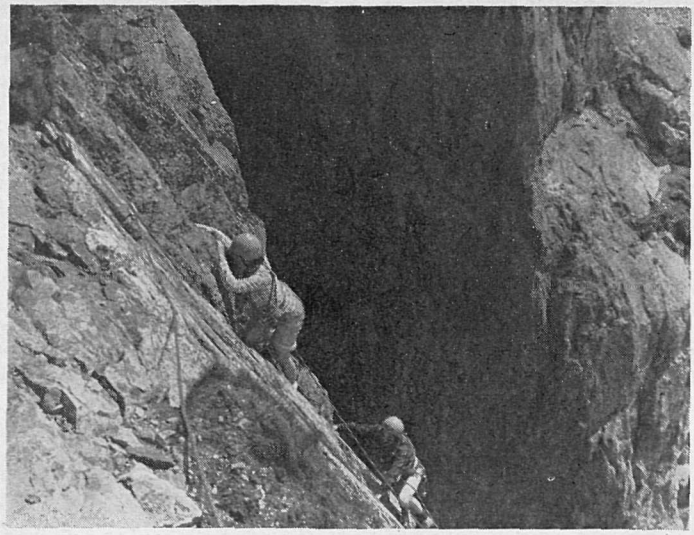
This active and enthusiastic club, has been organising three trips a term for the past few years. Separately run expeditions are often arranged by any interested parties for the intervening weekends and holidays.

I will outline briefly some of the ranges and places the Guy's M.C. have visited, since I first started climbing with them.

(1) **Scotland**—Cairngorms, Ben Nevis, Isles of Skye and Arran.

Visits are normally at Easter and involve either walking up the snowy peaks or ice climbing up the more direct gullies.

(2) **Wales**—Snowdonia. The club mainly goes to this scenic range on weekends. Pleasant walks over the mountains or more demanding rock climbs, of all



A struggling Meg Llewellyn-Smith. The Giants Crawl, Dow Crag, Coniston Old Man, The Lake District.

Photo by Nicholas H. Taylor.

calibres, can be enjoyed here. In January the Annual Dinner Meet is held there; last year Mr. Peter Davidson kindly provided some wine and gave a very witty speech after the meal. Past climbing epics were retold and embellished on, in the Presidents' Bar right into the small hours. Not surprisingly the next days climbing suffered from the effects of the night before.

(3) **Lake District.** Usually we take a longer weekend on a Bank Holiday to go here. As you will see in the photographs of the May Day weekend we were blessed with glorious weather, when a few people went swimming while some novices were being taken up their first rock-climbs.

(4) **Derbyshire.** We camp either outside the "Plough" public house on the banks of the Derwent, or stay in a hut owned by the University of London.

(5) **Cornwall.** This is best in the summer when the cliff walks and rock climbs can be most enjoyable. Swimming and other such sedentary pursuits are very pleasant, on this idyllic coastline, if the climbing proves too arduous.

(6) **Harrisons or Bowles Rocks.** Day trips to these small sandstone cliffs, in the heart of East Sussex not only provide a day's climbing, but are also a refreshing day out in the country, away from London.

Last summer members of the club travelled far and wide to the Himalayas, Iceland, the Drakensburgs, the Alps, and some quarries in Lancashire to explore and seek out new routes!

If you feel that you would like to become involved with our Mountaineering Club, we would be only too pleased to welcome you along. The club also organises slide shows, films, lecture visits and money raising schemes all of which provide extra-curricular interests and the chance to meet and know people from other years and courses. The Mountaineering Club pays for the van hire and insurance, so that only the food and petrol have to be bought; on average for a weekend the cost is around £3 to £7, depending of course on how much you eat and drink. Also we have climbing gear and tents so that any newcomers have to provide their own sleeping bags, waterproofs and boots.

If you are interested please write to the Secretary, Guy's Mountaineering Club via the East Wing Pigeon Holes.

ANDRE HEDGER.

GUY'S DRY FLY FISHING CLUB

The trout fishing season ended on September 30th and the Guy's Dry Fly Fishers' team are now working hard for their last fixture of the season; grayling fishing against the Cookham Angling Society. Nevertheless it was nice to see some of the big names in Guy's Dry Fly fishing taking time off, from hours of endless practice, at Lady Jane Finsley's coming out party last week. Sir Adrian Weston was trying a few deft casts in the direction of Lady Jane's younger sister, Harriet, but enjoyed his usual lack of success. She quickly had him in the weed and he was still trying to decide, who to make advances to next, when he discovered that he had left his familiar Fisherman's lozenges at home, and had to leave. Chris Parker was chatting avidly to Lady Jane's hairdresser, Ronnie, but it was again left to Dick Reading to provide the big news of the party. At midnight he declared his intention to make Lady Jane his wife or, as he put it in his own words, "to make an honest woman of her", but unfortunately neither she nor Ronnie were anywhere to be found. Incidentally, Lord Finsley has objected to the word "obtainable" being used to describe Lady Jane. In his letter he says "we all know that Jane is obtainable but there was no need to say so publicly".

The number of applications to join the Guy's Dry Fly Fishing Club have been overwhelming and Sir Adrian Weston says that in order to balance numbers, he is only able to offer places to ladies with experience.

Autumn fixtures are now largely complete, but here's one event not to be missed :

November 14—Hatchards 3.00 p.m. Sir Adrian Weston will be signing copies of his book, "The puzzling mind of the trout—a discussion".

M.D.

THE GORDON MUSEUM AUDIO-VISUAL SECTION

Brendan Hicks

This complete list of programmes is being published for the benefit of:

(a) Students, who may not realise the range of material available;

(b) Junior staff, who will find many of these programmes valuable for their own learning.

(c) Those who teach, who may find material which complements their courses and to which students might be directed. Some teachers may not be aware of the enormous classified slide collection from which slides are available on loan. Mr. Daws, the Chief Technician, will be happy to advise prospective users.

The ICI Series on Cardiac Auscultation is an example of programmes whose users will range from absolute beginners to post-graduates such as cardiac registrars. Each of the eighteen "units" in this series is made up of a book, a videocartridge, a sound cassette and a set of slides, each "unit" relating to one structural heart lesion. Programmes like this can be stimulating either as vehicles for individual learning or as the basis for small group discussions, tutorials, etc.

Viewing arrangements

These programmes are available from the Curator's office for use between 9.00 a.m. and 5.00 p.m. (occasionally later, by special arrangement), Monday to Friday.

VIDEO-CARTRIDGES

ISI Series on Auscultation

ICI–1 Auscultation and the normal heart
ICI–2 Pure mitral stenosis
ICI–3 Pure mitral regurgitation
ICI–4 Mitral stenosis and regurgitation
ICI–5 Pure aortic stenosis
ICI–6 Pure aortic regurgitation
ICI–7 Aortic stenosis and regurgitation
ICI–8 Tricuspid valve disease
ICI–9 Atrial septal defect
ICI–10 Ventricular septal defect
ICI–11 Persistent ductus arteriosus
ICI–12 Pulmonary valve stenosis
ICI–13 Fallot's tetralogy
ICI–14 Coarctation of the aorta
ICI–15 Supravalvular aortic stenosis
ICI–16 Subvalvular aortic stenosis
ICI–17 Idiopathic hypertrophic sub-aortic stenosis
ICI–18 Transposition of the great arteries

General Series

V–1	Examination of the cardiovascular system	29 mins
V–2	Examination of the respiratory system	19 mins
V–3	Lung sounds	20 mins
V–4	Examination of the cranial nerves	30 mins
V–5	Examination of motor and sensory nerves	52 mins
V–6	Aetiology of multiple sclerosis	31 mins
V–7	The Hidden Threat (slow viruses)	28 mins
V–8	Asthma, assessing the severity and monitoring recovery	30 mins
V–10	Disorders of language	32 mins
V–11	Speech disorders in adults	
V–12	Gait	34 mins
V–13	Congenital dislocation of the hip	41 mins
V–14	Gastrointestinal history taking in childhood	1–22 mins
	Pre-operative assessment for anaesthesia	28–43 mins

V–15 Aetiology of Graves disease 23 mins
V–16 Heart disease in pregnancy 22 mins
V–17 Intrauterine growth retardation 30 mins
V–18 Antepartum haemorrhage 25 mins
V–19 Multiple pregnancy 21 mins
V–20 Pre-eclampsia 29 mins
V–21 Postpartum haemorrhage 23 mins
V–22 Examination of the Child:
Part 1—Older children and toddlers 25 mins
Part 2—Infants 16 mins
V–23 Peritoneal dialysis 21 mins
V–24 Liver biopsy 25 mins
V–25 Breast feeding 25 mins
V–26 Examination of the abdomen (Mr. Rendall) 25 mins
V–27 Examination of the abdomen (Mr. Maynard) 30 mins
V–28 "Mixing a bottle feed" 14 mins
V–29 Therapeutics of terminal pain 33 mins
V–30 Recent laboratory advances in genetic counselling 43 mins
V–31 Principles of genetic counselling 35 mins
V–32 Examination of the lower limb in peripheral venous disease 31 mins
V–33 Examination of the lower limb in peripheral arterial disease
V–34 Clinical nutrition: nutritional anaemias 28 mins
V–35 Clinical nutrition: the metabolic nutritional aspects of severe injury 21 mins
V–36 Clinical nutrition: Rickets 25 mins
V–37 The Unkind Inheritance (Sickle Cell Disease) 45 mins
V–38 Unilateral visual loss 37 mins
V–39 Specific immunological unresponsiveness 39 mins

TAPE SLIDE PROGRAMMES

Cardiology

A–1 Heart sounds and murmurs (I–IIX) 15 mins x 8
A–2 Venous disorders of the lower limb (Mr. A. R. Calo) 30 mins
A–3 Arrhythmias after myocardial infarction 51 mins
A–4 Radiographic anatomy series—The Heart 20 mins
A–5 Current Status of Beta Blocking agents—part 1 22 mins
A–6 Current status of Beta Blocking agents—part 2 17 mins
A.ICI–1 Auscultation and the normal heart 15 mins
A.ICI–2 Pure mitral stenosis 15 mins
A.ICI–3 Pure mitral regurgitation 11 mins
A.ICI–4 Mitral stenosis and regurgitation 11 mins
A.ICI–5 Pure aortic stenosis 10 mins
A.ICI–6 Pure aortic regurgitation 12 mins
A.ICI–7 Aortic stenosis and regurgitation 11 mins
A.ICI–8 Tricuspid valve disease 10 mins
A.ICI–9 Atrial septal defect 13 mins
A.ICI–10 Ventricular septal defect 13 mins
A.ICI–11 Persistent ductus arteriosus 12 mins
A.ICI–12 Pulmonary valve stenosis 10 mins
A.ICI–13 Fallot's tetralogy 12 mins
A.ICI–14 Coarctation of the aorta 8 mins
A.ICI–15 Supravalvular aortic stenosis 9 mins
A.ICI–16 Subvalvular aortic stenosis 10 mins
A.ICI–17 Idiopathic hypertrophic sub-aortic stenosis 10 mins
A.ICI–18 Transposition of the great arteries 8 mins

Respiratory

B–1 How to read a chest film (Dr. L. Kreel) 17 mins
B–2 The large homogeneous or confluent shadow (Dr. L. Kreel) 44 mins
B–3 Hypertransradiancy of the lung (Dr. L. Kreel) 17 mins
B–4 Nodular shadows in the lung fields (Dr. L. Kreel) 26 mins
B–5 Emphysema and chronic bronchitis (Dr. Lane) 34 mins
B–6 Asbestosis (Dr. A. Somner) 18 mins
B–7 Sarcoidosis (Dr. P. Leggat) 17 mins
B–8 Bronchial carcinoma (Dr. B. Stack) 21 mins
B–9 Radiographic anatomy series—The Thorax 19 mins

Gastroenterology

C–1 Examination of the abdomen (Drs. Wittle & Javett) 22 mins
C–2 Bowel Sounds (Dr. B. Hicks) 22 mins
C–3 Cirrhosis—Part I (C. Holdsworth) 15 mins
C–4 Cirrhosis—part II (C. Holdsworth) 15 mins
C–5 Acute abdomen—part I—inflammation (Mr. A. Smith) 15 mins
C–6 Acute abdomen—part II—obstruction (Mr. A. Smith) 15 mins
C–7 Acute abdomen—part III—perforation (Mr. A. Smith) 17 mins
C–8 Gall stones (Mr. R. Irving) 29 mins
C–9 Cancer of Colon & rectum (Mr. A. Smith) 17 mins
C–10 Peptic ulcer 20 mins
C–11 Ulcerative colitis 18 mins
C–12 Radiographic anatomy series—Gastrointestinal tract 21 mins
C–13 Radiographic anatomy series—Posterior abdominal wall & urinary tract 20 mins
C–14 Tumours of the Salivary Glands 29 mins
C–15 The pathophysiology of surgical jaundice 32 mins

Rheumatology and Orthopaedics

D–1 Radiology of joint disease (Dr. R. Hacking) 18 mins
D–2 Colles fracture 17 mins
D–3 Investigations of a patient with arthritis 24 mins
D–4 Radiographic anatomy series—Upper limb 16 mins
D–5 Radiographic anatomy series—Lower limb 18 mins
D–6 Radiographic anatomy series—The Spine 18 mins
D–7 Radiographic anatomy series—The Pelvis 18 mins

Genitourinary Medicine and Surgery

E–1 Urinary calculi (Mr. Kinder) 18 mins
E–2 Sexually transmitted diseases today (Dr. Oriel) 20 mins
E–3 Gonorrhoea (Dr. Oriel) 21 mins
E–4 Non-gonococcal urethritis (Dr. Oriel) 22 mins
E–5 Infective vaginal discharge (Dr. Oriel) 20 mins
E–6 Homosexuality and its problems (Dr. Oriel) 20 mins

Nephrology

F–1 Acute renal failure (I–IV) (Prof. Cameron) 20 mins x 4
F–2 Renal immunology (Dr. K. Peters) 48 mins
F–3 Cysts and tumours of the kidney (Mr. Williamson) 28 mins

Immunology

G–1 Immune deficiency states (Prof. Lessof) 20 mins
G–2 Henoch-Schonlein purpura (Dr. R. Jackson) 13 mins

Endocrinology and Metabolism

H–1 Introduction to endocrinology (Dr. J. Hadden) 18 mins
H–2 Hyperthyroidism (Prof. R. Hall) 20 mins
H–3 Acromegaly—a clinical approach (Prof. R. Hall) 38 mins
H–4 Introduction to diabetes mellitus (Dr. J. Hadden) 35 mins
H–5 Pituitary releasing hormones (Prof. M. Besser) 45 mins
H–6 Gut endocrinology (Dr. S. R. Bloom) 40 mins
H–7 Potassium deficiency (Prof. R. Cohen) 18 mins
H–8 Clinical disturbances of sodium and water balance 20 mins

H–9 Fibre—its importance in human nutrition 40 mins
H–10 Skeletal manifestations of endocrine disorders 29 mins

Haematology
I–1 Polycythaemia rubra vera (Dr. J. S. Malpas) 12 mins
I–2 Treatment of acute leukaemia (Prof. Hamilton Fairley) 26 mins
I–3 Treatment of Hodgkin's disease in 1974 (Prof. Hamilton Fairley) 25 mins
I–4 Hodgkin's disease and the reticuloses 22 mins

Ophthalmology
J–1 Examination of the eye (Dr. M. Bedford) 20 mins
J–2 The red eye (Dr. M. Bedford) 26 mins
J–3 "I can't see very well" (Dr. M. Bedford) 23 mins

Dunhill Dermatology Section
K–1 Lichen Planus (Dr. E. Cronin) 35 mins
K–2 Scabies (Dr. E. Cronin) 30 mins
K–3 Generalised pustular psoriasis (Dr. T. Ryan) 28 mins
K–4 Skin diseases and the eye (Dr. J. Gilkes) 18 mins
K–5 Dermatitis herpetiformis (Dr. T. Ryan) 20 mins
K–6 Acne vulgaris (Dr. R. Marks) 27 mins
K–7 Rosacea (Dr. R. Marks) 28 mins
K–8 Pityriasis rosea (Dr. E. Cronin) 24 mins
K–9 Pigmented naevi (Dr. H. Baker) 32 mins
K–10 Bacteria pathogenic on human skin (Dr. W. Noble) 23 mins
K–11 Skin tumours (Mr. Lawrie) 19 mins
K–12 Psoriasis—some clinical aspects (Dr. J. Delaney) 20 mins
K–13 Quiz—questions (Dr. B. Leppard) 10 mins
K–14 Quiz—answers (Dr. B. Leppard) 22 mins
K–15 Statistics (Dr. W. Noble) 22 mins
K–16 Cutaneous leishmaniasis (Dr. W. Griffiths) 20 mins
K–17 Congenital abnormalities of the nails (Dr. P. Samman) 15 mins
K–18 Cysts of the skin (Dr. B. Leppard) 15 mins
K–19 Immunofluorescence of the skin (Dr. A. Knight) 12 mins
K–20 Drug rashes (Dr. A. Knight) 18 mins
K–21 Bacterial infections of the skin (Dr. L. Millard) 23 mins
K–22 Gardeners syndrome (Dr. B. Leppard) 20 mins
K–23 Cutaneous manifestations of diabetes (Dr. W. Barker) 18 mins
K–24 Common viral infections of the skin (Dr. L. Millard) 20 mins
K–25 Psoriasis (Dr. J. Delaney) 29 mins
K–26 Epidermal tumours (Dr. J. Delaney) 40 mins
K–27 Percutaneous penetration 35 mins
K–28 Cell reproduction in skin diseases—cell proliferation kinetics
K–29 Superficial fungal & yeast infections 29 mins

Genetics
L–1 Genetic disease—part I (Prof. C. Havard) 19 mins
L–2 Genetic disease—part II (Prof. C. Havard) 18 mins
L–3 Principles of genetic counselling for dermatologists (Dr. Wells) 18 mins
L–4 Epidemiological techniques (Dr. W. Noble) 15 mins
L–5 Basic Genetics—on loan from I.C.I.

Gynaecology and Obstetrics
M–1 Total abdominal hysterectomy (Mr. T. Coltart) 12 mins
M–2 Irritation of the vulva (Mr. C. Hudson) 19 mins
M–3 Fibroids (Mr. A. Letchworh) 17 mins
M–4 Rhesus incompatibility (Prof. Fairweather) 25 mins
M–5 Multiple pregnancy—part II (Mr. C. Hudson) 13 mins
M–6 Breech delivery (Mr. C. Hudson) 25 mins
M–7 Postpartum haemorrhage—part I (Dr. Bonnar) 14 mins
M–8 Postpartum haemorrhage—part II (Dr. Bonnar) 13 mins
M–9 Antepartum haemorrhage (Prof. Dewhurst) 40 mins
M–10 Intersexual disorders (Dr. Bonnar)
M–11 Chromosomal abnormalities 42 mins
M–12 Coagulation disorders in obstetrics 25 mins
M–13 Elements of Sonar 40 mins
M–14 Hydatidiform mole
M–15 Heart disease in pregnancy

Neurology
N–1 Diagnosis of peripheral nerve lesions (USPHS) 20 mins
N–2 Ulnar nerve lesions (Mr. N. Barton) 51 mins
N–2 cnt. Ulnar nerve lesions (slides)
N–3 Subarachnoid haemorrhage (Mr. Maurice-Williams) 17 mins
N–4 Median Nerve Lesions 62 mins
N–5 Acoustic neuromas 40 mins
N–6 Aphasia—Whose problem? Part I 32 mins
N–7 Aphasia—Whose problem? Part 2 26 mins

Trauma, Burns and Emergencies
O–1 Vascular injuries (Mr. J. Lumley) 19 mins
O–2 Blunt abdominal injuries (Mr. A. Calo) 27 mins
O–3 Head injuries (Mr. J. Lumley) 23 mins
O–4 Burns
O–5 Medical radiological emergencies
O–6 Skin suture (Dr. Latimer-Sayer)
O–7 Suturing
O–8 Tracheostomy (Dr. G. Parbrook) 26 mins
O–9 Shock (Mr. R. Irving) 25 mins

Pathology
P–1 Role of pathology, materials and methods Chapter 2, Lesson 1 & 2
P–2 Role of pathology, materials and methods Ch. 2 Lesson 3
P–3 Man, environment and disease Ch. 3 Lesson 1 & 2
P–4 Man, environment and disease Ch. 3 Lesson 3
P–5 Modification of effects of external environment at body surfaces Ch. 4 Lesson 1 & 2
P–6 Cell homeostasis Ch. 5 Lesson 1 & 2
P–7 Cell homeostasis Ch. 5 Lesson 3
P–8 Tissue homeostasis Ch. 6 Lesson 1 & 2
P–9 Organ, body & community homeostasis Ch. 7 Lesson 1
P–10 Immunity Ch. 8 Lesson 1 & 2
P–11 Immunity Ch. 8 Lesson 3
P–12 Inflammatory response & repair Ch. 9 Lesson 1 & 2
P–13 Inflammatory response & repair Ch. 9 Lesson 3 & 4
P–14 Inflammatory response & repair Ch. 9 Lesson 5
P–15 Neoplasia Ch. 10 Lesson 1 & 2
P–16 Neoplasia Ch. 10 Lesson 3 & 4
P–17 Abnormal accumulations Ch. 11 Lesson 1 & 2
P–18 Infection and infectious diseases Ch. 12 Lesson 1 & 2
P–19 Effects of some physical environmental agents on body homeostasis Ch. 13 Lesson 1 & 2
P–20 Circulatory disturbances Ch. 14 Lesson 1 & 2
P–21 Circulatory disturbances Ch. 14 Lesson 3 & 4
P–22 Developmental abnormalities Ch. 15 Lesson 1 & 2
P–23 Ageing Ch. 16 Lesson 1
P–24 History of pathology Ch. 17 Lesson 1

Safety

S–1 Safety in the Laboratory
S–2 Manual handling in Industry

Miscellaneous

Z–1 Prostaglandins in medicine (Dr. A. Bennett) 35 mins
Z–3 Nature & management of pain in terminal malignant diseases (sound only) (Dr. C. Saunders) 42 mins
Z–4 Mechanism of action of anti-microbial & other cytotoxic drugs—part I (Prof. R. Spector)
Z–5 Mechanism of action of cytotoxic drugs—part II (Prof. R. Spector)
Z–6 Rabies (Dr. D. Warrel) 28 mins
Z–7 Diagnosis of lumps in the neck (Mr. A. Calo) 25 mins
Z–8 Hoarseness 26 mins

PROGRAMMES AVAILABLE FOR THE *CINE-LOOP PROJECTOR*

Ichthyosis linearis circumflexa (*Dunhill*)
Mal de Meleda (*Dunhill*)
Subcorneal pustular dermatosis (*Dunhill*)
Early cutaneous leishmaniasis (*Dunhill*)
Late cutaneous leishmaniasis (*Dunhill*)
Demodex folliculorum (*Dunhill*)
Turban tumour (*Dunhill*)
Pellagra and other avitaminoses in the Bantu (*Dunhill*)
Sputum
Soft tissue injuries (*donated by Merck, Sharp and Dohme*)
Diuretic therapy (*donated by Searle*)
Understanding cardiac rhythms (*donated by Searle*)
Embryology—development of heart circulation
Embryology —oocyte to implantation

THE DUNHILL DERMATOLOGY SECTION OF THE GORDON MUSEUM

Facilities are available for:

A. Individual Students

(a) Two individual study units in two corners, each with a table and chair for a single student to write and study. In addition there are good facilities for individual study in the room next door on the ground floor.

(b) Teaching machines of two types are available which will accept the aforementioned tape-slide programmes.

(c) The Towne moulages—carefully stored, and with a planned programme to show all of them over a period of time.

B. *For Groups of up to 15 Students*

Table and chairs for a tutorial group. Projection facilities for 2in. x 2in. transparencies. Mobile blackboard. Television to show video cartridges.

C. For Larger Groups

There are the same facilities, but these are probably best dealt with in the lecture room, which is also on the Ground floor of the Gordon Museum and should be pre-booked in the Curator's office, telephone extension number 3372.

HOSPITAL INFORMATION

PAPERS BY GUY'S MEN

Amlot, P. L. *and* Adinolfi, M. B2-microglobulin, a tumour marker of lymphoproliferative disorder. (Correspondence.) **Lancet,** 1978, **2,** 476.

Atkins, Sir H. Sensible drinking. **Brewing Review,** 1978, **1,** 2.

Butcher, G. A., Mitchell, G. H. *and* Cohen, S. Antibody mediated mechanisms of immunity to malaria induced by vaccination with plasmodium knowlesi merozoites. **Immunology,** 1978, **34,** 77.

Cameron, J. S. *and others.* Clinicopathological conference: two children with kidney disease. **British Medical Journal,** 1978, **2,** 867.

Cantwell, B. M. J., Tong, D., Minton, M., Rubens, R. D. *and* Hayward, J. L. Tamoxifen and male breast cancer. (Correspondence.) **Lancet,** 1978, **2,** 582.

Chantler, C. *and others.* Mortality and morbidity of reusing dialysers: a report by the registration committee of the European Dialysis and Transplant Association. **British Medical Journal,** 1978, **2,** 853.

Corless, D. *and others.* Response of plasma-25-hydroxyvitamin D to ultraviolet irradiation in long-stay geriatric patients. **Lancet,** 1978, **2,** 649.

Edwards, A. C. *and* Sowton, E. Management of embolised central venous catheters. **British Medical Journal,** 1978, **2,** 669.

Gregson, N. A., Leibowitz, S., Kennedy, M. C. *and others.* Galactocerebroside is a specific cell-surface antigenic marker for oligodendrocytes in culture. **Nature,** 1978, **274,** 813.

Harrison, T. A. Aspects of treatment in portal phlebothrombosis—the role of thrombectomy. **Annals of the Royal College of Surgeons of England,** 1978, **60.**

Harvey, W. Careers for non-medical scientists. (Correspondence.) **Lancet,** 1978, **2,** 531.

Howorth, P. J. N. Prevention of alcoholic liver disease. (Correspondence.) **Lancet,** 1978, **2,** 529.

Hughes, C. A., Bates, T. *and* Dowling, R. H. Cholecystokinin and secretin prevent the intestinal mucosal hypoplasia of total parenteral nutrition in the dog. **Gastroenterology,** 1978, **75,** 34.

Jeanes, A. L. Misdiagnosis of amoebiasis. (Correspondence.) **British Medical Journal,** 1978, **2,** 895.

Jefferys, D. B. *and* Vale, J. A. Malignant presothelioma and gas-mask assemblers. **British Medical Journal,** 1978, **2,** 607.

Lewis, J. L. Postmastectomy patients—helping them to face the future. **Modern Medicine,** 1978, **23**(9), 55.

Losito, A., Williams, D. G., Cooke, G. *and* Harris, L. The effects on polymorphonuclear leucocyte function of prednisolone and azathioprine in vivo and prednisolone, azathioprine and 6-mercaptopurine in vitro. **Clinical and Experimental Immunology,** 1978, **32,** 423.

Macdonald, I. Kayser, A. *and* Pacy, D. Some effects, in man, of varying the load of glucose, sucrose, fructose, or sorbitol on various metabolites in blood. **American Journal of Clinical Nutrition,** 1978, **31,** 1305.

Maisey, M. N. Nuclear medicine. 1: introduction. **Hospital Update,** 1978, **4,** 385.

Maisey, M. N. Nuclear medicine. 3: brain scanning. **Hospital Update,** 1978, **4,** 521.

Ogg, C. S. Ten years on: nephrology. **Update,** 1978, **17,** 469.

Parbtani, A. *and* Cameron, J. S. Platelets, serotonin, migraine, and immune-complex disease. (Correspondence.) **Lancet,** 1978, **2,** 679.

Parkinson, C. *and another.* Acute epiglottitis in an adult causing sudden death. (Correspondence.) **Lancet,** 1978, **2,** 475.

Pembrey, M. E. *and another.* Sickle cell anemia. (Correspondence.) **Annals of Internal Medicine,** 1978, **89,** 145.

Rees, R. J. W. *and others.* The activity of thiacetazone, thiambutosine, thiocarlide and sulphamethoxypyridazine against Mycobacterium lepræ in mice. **Leprosy Review,** 1978, **49,** 101.

Rees, R. J. W. *and others.* Combined therapy in principle and practice for the control of dapsone resistance. **Leprosy Review,** 1978, **49,** 97.

Rees, R. J. W. *and others.* Proven primary dapsone resistance in leprosy—a case report. **Leprosy Review,** 1978, **49,** 127.

Robinson, B. W. S. Medical screening of old people. (Correspondence.) **Lancet,** 1978, **2,** 532.

Scully, C. *and another.* Oral manifestations of communicable diseases. **Update,** 1978, **17,** 745.

Stein, B. *and* Volans, G. N. Dixarit overdose: the problem of attractive tablets. **British Medical Journal,** 1978, **2,** 667.

Tanner, E. R. *and another.* Starting early to prevent muscle disability in old age. **Modern Geriatrics,** 1978, **8**(9), 53.

Wooley, P. H. *and* Panayi, G. S. Studies of lymphocytes in rheumatoid arthritis. 1. Uptake of 125 1-heat aggregated human 1gG by Fc-receptor bearing lymphocytes. **Annals of the Rheumatic Diseases,** 1978, **37,** 343.

JUNIOR STAFF APPOINTMENTS 1978/79

The following appointments and re-appointments have been made for the period commencing 1st October, 1978:—

Medical Registrars

Dr. J. A. Vale (S.R.)	(Guy's)
Dr. J. R. Webb	(Guy's)
Dr. T. J. Meredith	(Guy's)
Dr. P. E. T. Isaacs (S.R.)	(on study leave abroad)
Dr. P. Maton (Locum)	(Lewisham)
Dr. P. G. Jackson (S.R.)	
Dr. J. C. W. Edwards	(St. Olave's)
Dr. C. M. C. Allen	(Guy's)
Dr. T. W. Higgenbottam (S.R.)	(New Cross)
Dr. T. H. Lee	(Brook General Hospital)

Senior House Officers in General Medicine

Dr. S. Raper	(Vocational)
Mr. M. J. Tidman	(Vocational)
Dr. P. Emery	
Dr. D. Stephens	(Vocational)
Dr. A. A. Quyyumi	
Dr. J. Efthimiou	
Dr. C. W. G. Vevers	
Dr. C. A. Holden	
Dr. S. A. Watson	

Registrars to the Renal Unit

Dr. G. Neild (S.R.)	(Locum)
Dr. A. H. Gershlick (S.H.O.)	(1.6.78–30.11.78)
Dr. M. Bamber (S.H.O.)	(1.9.78–28.2.79)

Registrar to Intensive Care and Clinical Toxicology

Dr. M. Helliwell

Registrar in Endocrinology and Nuclear Medicine

Dr. J. Ayres

Senior Registrar in Nuclear Medicine

Dr. A. J. Hilson (S.R.)

Surgical Registrars

Mr. J. Little (S.R.)	(Guy's)
Mr. W. Owen	(Guy's)
Mr. M. Lavelle	(Guy's)
Mr. T. K. Day	(Guy's)
Mr. J. L. Lewis	(Lewisham)
Mr. H. G. Sturzaker	(G.O.S./New Cross/ Guy's)
Mr. H. Ishmail (S.R.)	(Guy's/G.O.S./New Cross)
Mr. R. Pollard (S.R.)	(St. Olave's)
Mr. H. A. Goudarzi-Langroudi	(St. Olave's)
Mr. R. Dick	(Greenwich)
Mr. J. N. L. Simson (S.R.)	Bromley to 31.3.78 then Farnborough)
Mr. Kinder	(Farnborough)
Mr. K. Boffard	(Pembury)
Mr. J. Payne	(Sabbatical)
Mr. O. Davison	(Lecturer)
Mr. G. Davies	(Lecturer)
Mr. S. Chapman-Nyaho	(Cuckfield)

Senior House Officers in General Surgery

Dr. A. West	(Guy's/Maudsley)
Dr. M. Thick	(Guy's/Maudsley/Breast Unit, Edgware)
Dr. P. M. Malone	(Breast Unit/Edgware/ Guy's)
Dr. K. G. Brame	Maudsley/Breast Unit/ Guy's
Dr. R. K. Forber	(Orthopaedic 31.3.79)
Dr. R. A. Carver	(Edgware/Guy's/ Orthopaedic)
Dr. R. W. T. Nichols	(Ashford/Maudsley/ Breast Unit)
Dr. J. V. Bryne	(Eastbourne to 31.3.79 then Ashford)

Registrars in the ENT Department

Mr. P. B. Ashcroft (S.R.)	(Guy's to 31.12.78 then Lewisham)
Mr. N. J. Marks (S.R.)	(Lewisham to 31.12.78 then Guy's)
Dr. R. P. Mills	
Dr. M. P. Stearns	

Obstetric Registrars

Mr. D. J. W. Wilkins (S.R.)	(Farnborough)
Mr. N. G. J. Pipe (S.R.)	(Guy's)
Mr. D. A. Maclean	(Guy's to approx. 15.10.78 then vacant)

Registrar in Rheumatology

Dr. P. J. Gow (Locum) (S.R.)	(Brighton to 30.11.78)
Dr. B. J. Sweetman (S.R.)	(Guy's)
Dr. A. J. Griffin (S.R.)	(Study leave 1 year 1.8.78)
Dr. G. Huston (S.R.)	(Orpington/Guy's)
Dr. J. G. Highton	
Dr. M. R. Laurent (S.R)	(Greenwich/Guy's)
Dr. R. Armstrong	
Dr. O. Duke	

Registrar in Cardiology

Dr. R. J. Wainwright (S.R.)	
Dr. J. W. Upward	
Dr. J. W. Gillgrass (S.H.O.)	
Dr. P. Emery (S.H.O.)	
Dr. D. L. Smaldon (S.R.)	

Registrars in Clinical Pathology

Dr. A. G. Hellyar
Dr. R. H. Wallace-Simpson
Dr. N. L. K. Fagg
Dr. E. A. Caffrey

Registrar in Microbiology

Dr. M. T. Dalton (S.R.) (Locum)

Registrar in Haematology

Dr. H. J. H. Williams (S.R.)

Senior House Officers in Clinical Pathology

Dr. C. F. Rose
Dr. J. Van De Pette
Dr. S. J. Kenny

Registrars in Psychological Medicine

Dr. T. Kidger (S.R.)	(Dr. Gaind—St. Olave's)
Dr. M. Alker (S.R.)	(Prof. Watson/Dr. Fry —Guy's/St. Olave's)
Dr. R. C. S. Furlong (S.R.)	(Bexley then Dr. Fleminger—Guy's)
Dr. D. MacDiarmid (S.R.)	(Bexley)
Dr. S. L. Davenport (S.R.)	(Bexley)
Dr. Hill	(Emergency Service; (Guy's)

Dr. A. M. Leader (Dr. Fleminger—Guy's)
Dr. M. J. B. Hobbs (Prof. Watson—Guy's)
Dr. P. H. Hollis (Dr. Fry—St. Olave's)
Dr. H. Standish-Barry (Dr. Gaind—St. Olave's
Dr. M. J. Taylor P/T

Senior House Officers in Psychological Medicine
Dr. Goepfert (Prof. Watson—Guy's)
Dr. J. Timbs (Prof. Watson—Guy's)
Dr. Anness (Dr. Fleminger—Guy's)
Dr. L. M. Brown (Dr. Fry—St. Olave's)
Dr. Vernon (Dr. Gaind—St. Olave's)
Dr. G. Tufnell (Dr. Fry/Dr. Gaind, St. Olave's)
Vacant (Psychogeriatrics/Day Hospital, St. Olave's)

Registrars in Child Psychiatry
Dr. P. van Boxel (S.R.)
Dr. G. M. G. McClure (S.R.) (Locum)
Dr. Darrock
Dr. D. Murphy (S.H.O.)

Orthopaedic Registrars
Mr. G. N. Boobbyer (S.R.) (Guy's)
Mr. J. D. Spencer (S.R.) (Hastings)
Mr. I. W. L. Bintcliffe (S.R.) (Guy's)
Mr. J. D'Arcy (S.R.) (Guy's)
Mr. R. D. Rawlins (S.R.) (Lewisham)

Orthopaedic and Casualty Officer
Dr. M. Azizogli

Registrar in Urology
Vacant (S.R.)

Registrars in Dermatology
Dr. D. J. Atherton (S.R.) (Until 28.11.78. Locum being appointed)
Dr. I. R. White
Dr. J. J. Horton (S.H.O.) (1.9.78–28.2.79)

Registrars in Diagnostic Radiology
Dr. S. Golding (S.R.) (Guy's)
Dr. P. J. Freyne (S.R.)
Dr. T. F. L. El-Sayed (S.R.)
Dr. D. F. Shelley (S.R.)
Dr. E. Avassepian (S.R.) (Greenwich)
Dr. M. R. Salari (S.R.)
Dr. A. Patel
Dr. M. Kalthoum
Dr. M. C. Harvey
Dr. A. C. Kesaria
Dr. H. J. Gilford
Dr. E. G. Mansi
Dr. C. G. Pinder
Dr. C. B. M. Hunt
Dr. M. W. Reeves

Registrars in Radiotherapy
Dr. V. B. Reddi (S.R.)
Dr. W. A. H. Bodger

Registrar in Neurology
Vacant (S.R.)
Dr. R. A. Metcalfe
Dr. K. B. Elkon (S.H.O.) (1.9.78–28.2.79)

Registrars in Ophthalmology
Mr. J. H. Ramsay (S.R.)
Mr. R. Harfitt (S.R.)
Dr. D. M. Calver (S.R.)
Mr. A. M. Orekoya

Senior House Officer in Ophthalmology
Dr. P. E. Kinnear
Dr. H. R. Atta
(2 S.H.O.'s)

Paediatric Registrars
Dr. H. Bluett (S.R.)
Dr. A. E. Briggs (S.R.) (Locum)
Dr. T. W. J. French (Brighton)
Dr. P. W. G. Evans (Guy's 1.11.78)
Dr. G. Baird (P/T) (S.R.)
Dr. R. W. A. Jones (Medical School)
Dr. L. A. Broughton (S.H.O.) (1.4.78–30.11.78)
Dr. R. A. McCubbin (S.H.O.) (1.6.78–31.1.79)
Dr. J. R. Bayly (S.H.O.) (1.6.78–30.11.78)
Dr. R. Jukes (S.H.O.) (1.9.78–31.3.79)
Dr. J. S. G. Bamforth (S.H.O.) (1.12.78–30.11.78)
Dr. A. E. Brusby (S.H.O.) (1.1.78–31.1.79)
Dr. T. G. Powell (S.H.O.) (1.3.78–31.3.79)
Dr. T. Y. D. Leung (S.H.O.) (1.6.78–31.5.79)
Dr. A. C. Walsh (S.H.O.) (1.8.78–31.7.79)
Dr. M. Cromie (S.H.O.) (1.10.78–30.9.79)
Dr. D. W. Beverley (S.H.O.) (9.10.78–31.3.79) (Paediatric Nephrology)

Registrars in Thoracic Surgery
Mr. C. T. M. Sang (S.R.) (Going to St. Thomas' 1.1.79)
Mr. J. E. Dussek (S.R.) (Brook/Guy's 1.1.79)
Mr. O. J. Lau (S.R.)
Mr. J. R. Pepper (S.R.)
Mr. W. E. Morgan (St. Thomas' until 31.12.78 then Brook for one year)
Dr. D. V. Skinner (S.H.O.) (1.7.78–31.12.78)
Dr. T. Govindasamy (S.H.O.) (1.9.78–28.2.79)

Registrars in Anaesthetics
Dr. R. B. Plummer (S.R.) (Brighton/1.12.78/Guy's)
Dr. R. M. Bowen-Wright (S.R.) (Guy's 1.12.78/Brighton)
Dr. T. J. Wilson (S.R.) (Canterbury/1.10.79 (Guy's)
Dr. G. Bradburn (S.R.) (Guy's/1.10.79/ Canterbury)
Dr. S. K. Pratley (S.R.) (Guy's/rotate 1.4.78/ to Lewisham)
Dr. G. J. Baldock (S.R.) (Lewisham rotate 1.4.78/ to Guy's)
Dr. J. H. Cook (S.R.) (Brook rotate 1.4.78/ Guy's)
Dr. W. S. Rao (S.R.) (Guy's rotate 1.4.78/ Greenwich)
Dr. J. J. Kothari (S.R.) (Greenwich rotate 1.4.78/ Brook)
Dr. K. Naquishbandi (S.R.) (Hastings)
Dr. S. N. Kilpatrick (S.R.) (Guy's)
Dr. M. A. Thompson (S.R.) (Guy's)
Dr. J. E. Clarke (Guy's)
Dr. J. D. McArthur (Brighton)
Dr. T. P. Davies (Guy's)
Dr. G. K. D. Nath (East Grinstead)
Dr. M. M. Bassilious (Guy's until 31.3.79)
Dr. M. P. Weerasinghe (Lewisham until 31.3.79)
Dr. M. Lewis (Guy's)
Mr. M. J. Boscoe (Guy's)
Dr. A. H. C. Scott (Guy's)
Dr. N. D. Bardsley (S.H.O.) (1.7.78–30.6.79)
Dr. T. M. Baylis (S.H.O.) (1.10.78–30.9.79)
Dr. J. Glover (S.H.O.) (1.9.78–31.8.79)
Dr. C. Carnegie (S.H.O.) (1.9.78–31.8.78)

Registrars in Geriatric Medicine
Dr. B. Robinson (S.R.) (Locum to 23.10.78 at New Cross)
Dr. P. Crome (S.R.) (New Cross)
Dr. J. H. Pearson (S.R.) (Locum at Hastings)
Vacant (S.R.) (Brighton)
Dr. E. J. Heyer (G.P.)
Vacant (R.)

Registrar in Genito-Urinary Medicine
Dr. K. L. Amasuriya (S.R.)
Dr. J. J. Rohatiner (G.P.)
Dr. L. R. Sausman (G.P.)
Mr. Orme Smith (A.D.S.)
Mr. D. J. McConnell (S.R.)
Miss M. A. Betteridge (S.R.)
Mr. R. M. Mordecai (C.A.)
Vacant (C.A.)
Mrs. J. Kirschen (Reg.)
Miss P. J. Davis (Reg.)

Department of Clinical Dental Surgery
Mr. Mace (S.R.)
(until 1.11.78) Vacant
Mr. J. M. Robertson
(S.R.) (East Grinstead)
Mr. P. J. Bathard-Smith
(S.R.)

Department of Oral & Maxillo Facial Surgery
Miss Finley (Reg.)
Miss R. E. Hickman (Reg.)
Mr. S. Likimani (Reg.)
Mr. M. P. Bennetts (Reg.)
Vacant (Reg.)
Mr. P. N. Sheppard (C.A.)
Miss J. M. Stewart (C.A.)

Department of Periodontology & Preventive Dentistry
Mr. J. R. Radford
(Reg). (Half Time)
Mr. C. D. Allen (Reg.) (Half Time)
Mr. C. A. Waterman
(C.A.)
Vacant (C.A.)
Mr. C. Wynne Davies
(C.A.)
Mr. P. J. Kerr (C.A.)
Mrs. Radford (C.A.)

Department of Dental Prosthetics
Mr. R. I. Jishi (Reg.)
Mr. P. N. Davidson (C.A.)
Mr. D. W. Martin (C.A.)
Mr. P. A. Swift (C.A.)
Mr. R. E. W. Pearce (C.A.)
Mr. P. B. Swiss (C.A.)
Mr. M. Malleson (C.A.)
Mr. W. A. V. Beare (C.A.)

Department of Conservative Dentistry
Mr. J. R. Radford
(Reg.) (Half Time)
Mr. C. D. Allen (Reg.) (Half Time)
Mrs. C. Osborne (C.A.)
Mr. R. A. Ellis (C.A.)
Mr. T. R. Pitt-Ford
(C.A.)
Mr. G. J. J.
Dewe Mathews (C.A.)
Mrs. F. M. Patterson
(C.A.)
Mr. A. A. MacDonald
(C.A.)
Mr. M. L. Schaller
(C.A.)
Mr. M. L. Maberley
(C.A.)
Mr. M. Malleson (C.A.)
Mr. D. M. Heyderman
(C.A.)
Mr. Invest (C.A.)
Mr. Goulden (C.A.)
Mr. A. A. Robinson
(C.A.) (1st November)
Mr. Wakeham (C.A.)
Mr. van der Berg (C.A.)

Department of Dental Radiology
Mr. B. W. Beeching (C.A.)

Primary Treatment Unit
Mr. R. A. J. Shaw (A.D.S.)

Dental Care of the Handicapped
Miss H. Dickinson
(A.D.S) (Child)
Mr. M. L. Maberley
(A.D.S.) (Adult)
Mr. Sculley (A.D.S.) (Adult)
Mr. P. J. Hill (A.D.S.) (Adult)

In Patient Dental Officer
Mr. G. P. Feaver (G.D.P.)

ALLOCATION OF MEDICAL S.H.O.s AND REGISTRARS

1st October, 1978

REGISTRARS

Dr. Houston/Professor Trounce/Dr. Knight	Dr. C. M. C. Allen
Professor Lessof/Professor Keen	Dr. J. R. Webb
Dr. Scott/Dr. Joiner	Dr. T. J. Meredith
Professor Dowling//Dr. Sladen	Dr. P. Maton
Endocrinology & Nuclear Medicine	Dr. J. Ayres
Cardiac Department	Dr. J. W. Upward
Rheumatology (1)	Dr. R. D. Armstrong
Geriatric Medicine/General Medicine, St. Olave's	Vacant
Rheumatology (2)	Dr. O. L. Duke
Intensive Care & Toxicology	Mr. M. Helliwell
St. Olave's	Dr. J. C. W. Edwards
New Cross (Chest Medicine)	Dr. T. W. Higginbottam

SENIOR HOUSE OFFICERS

	Oct. '78–Dec. '78	Jan. '79–Mar. '79
Dr. Scott & Dr. Joiner	D. Stephens	D. Stephens
Dr. Houston/ Prof. Trounce & Dr. Knight	A. A. Quyyumi	A. A. Quyyumi
Cardiology	P. Emery	P. Emery
Cardiology	J. Gillgrass	J. Gillgrass
ST. OLAVE'S		
A. Dr. MacLean	J. Efthimiou	J. Efthimiou
B. Dr. Hicks	G. W. G. Vevers	G. W. G. Vevers
NEW CROSS		
Medical Oncology (Breast Unit) Dr. Rubens	M. J. Tidman	C. A. Holden
General/Chest Medicine Prof. Clark/Dr. Cochrane	C. A. Holden	M. J. Tidman
General Medicine & Geriatrics Dr. Corless/Dr. Lewis	S. A. Watson	S. Raper
General Medicine & Rheumatology	S. Raper	S. A. Watson

	Apr. '79–June '79	July '79–Sept. '79
Dr. Scott & Dr. Joiner	N. Scott	N. Scott
Dr. Houston/Prof. Trounce & Dr. Knight	S. A. Watson	S. A. Watson
Cardiology	A. A. Quyyumi	A. A. Quyyumi
Cardiology		
ST. OLAVE'S		
A. Dr. MacLean	P. Emery	P. Emery
B. Dr. Hicks	M. J. Tidman	M. J. Tidman
NEW CROSS		
Medical Oncology		
(*Breast Unit*) Dr. Rubens	G. W. G. Vevers	J. Efthimiou
General/Chest Medicine		
Prof. Clark/Dr. Cochrane	J. Efthimiou	G. W. G. Vevers
General Medicine & Geriatrics		
Dr. Corless/Dr. Lewis	C. A. Holden	D. Stephens
General Medicine & Rheumatology	D. Stephens	C. A. Holden

SURGICAL REGISTRARS

Mr. Maynard & Mr. Ellis		J. Lyttle
Mr. Glover & Mr. Rendall/Dr. Tong		W. Owen
Mr. Beard & Mr. O'Flynn/Dr. Winter		M. Lavelle
Surgical Unit		T. K. Day
Lecturer—Surgical Unit		O. Davison
Lecturer—Surgical Unit		G. Davies
Bromley		J. Simson—31.3.79/ R. Kinder—30.9.79
Farnborough		R. Kinder—31.3.79/ J. Simson—30.9.79
Pembury		K. Boffard
Sabbatical		J. Payne
Cuckfield		S. Chapman Nyaho
Lewisham		J. Lewis
Greenwich		J. Dick

	1st Oct. '78–31st Jan. '79	1st Feb. £79–31st May '79
Breast Unit	W. McNickle	H. G. Sturzaker
Great Ormond Street	H. G. Sturzaker	H. Ismail
Intensive Care		
Mr. Yates	H. Ismail	W. McNickle

	1st June '79-30th Sep. '79
Breast Unit	H. Ismail
Great Ormond Street	W. McNickle
Intensive Care	
Mr. Yates	H. G. Sturzaker

	Oct. '78–Dec. '78	Jan. '79–Mar. '79
Urology—St. Olave's	H. Goudarzi	H. Goudarzi
General Surgery		
St. Olave's	R. Pollard	R. Pollard
Greenwich	J. Dick	J. Dick
Lewisham	J. Lewis	J. Lewis

	Apr. '79–June '79	July '79–Sept. '79
Urology—St. Olave's	*H. Goudarzi*	*H. Goudarzi*
General Surgery		
St. Olave's	R. Pollard	R. Pollard
Greenwich	J. Dick	J. Dick
Lewisham	J. Lewis	J. Lewis

SURGICAL SENIOR HOUSE OFFICERS

	Oct. '78–Dec. '78	Jan. '79–Mar. '79
Mr. Maynard & Mr. Ellis	M. Thick	A. West
Mr. Glover & Mr. Rendall }	A. West	R. A. Carver
Mr. Beard & Mr. O'Flynn }		
Oncology—Breast Unit	P. M. Malone	K. G. Brame
Neurology—Maudsley	K. G. Brame	M. Thick
Orthopaedic	K. Forber	K. Forber
Edgware General	R. A. Carver	P. M. Malone
Ashford Hospital	R. W. T. Nichols	R. W. T. Nichols
Eastbourne Hospital	J. V. Byrne	J. V. Byrne

	Apr. '79–June '79	July '79–Sept. '79
Mr. Maynard & Mr. Ellis	A. West	P. M. Malone
Mr. Glover & Mr. Rendall }	K. G. Brame	K. G. Brame
Mr. Beard & Mr. O'Flynn }		
Oncology—Breast Unit	M. Thick	R. W. T. Nichols
Neurology—Maudsley	R. W. T. Nichols	A. West
Orthopaedic	R. A. Carver	R. A. Carver
Edgware General	P. M. Malone	M. Thick
Ashford Hospital	J. V. Byrne	J. V. Byrne
Eastbourne Hospital	Vacant	Vacant

THE SIR COSMO AND LADY MABEL BONSOR SCHOLARSHIP

This Scholarship is awarded each year and applications are invited from members of the Guy's Hospital Nurses' League, c/o Nursing Administration, Guy's Hospital, London, SE1 9RT.

DEATH

SCOTT-EVELYN, DENNIS, O.B.E., M.D., M.R.C.P., on 26th September, 1978—in Northampton and formerly of Hove. (Guy's Hospital 1908–17 and 1919–20.)

ENGAGEMENTS

The engagement is announced between Nicholas Taylor and Judith Tranter.

The engagement is announced between Timothy Watson, dental student, and Cecily Cox, physiotherapist.

PERSONAL

SISSORS HAIRDRESSERS require models for their training school. Cut and wash £1.20, Sets or blowdry's 50p, Highlights from £3.50, Perms £5.50. All supervised by Top Hairdressers. Phone 352 7253.

CHANGE OF ADDRESS

Mr. F. J. Edgell, L.D.S., "Bellfield", Bristol Road, Chew Stoke, BS18 8OB.

GUY'S HOSPITAL GAZETTE

We should like to remind our readers that all copy for inclusion in the "Gazette" must be received 12 days before publication. Copy dates for the next 2 months are: 20th November 1978 and 15th January 1979.

Copy may be sent to us at 16, St. Thomas Street, S.E.1.

Birth, Marriage, Death and Change of Address notices are inserted without charge to subscribers.

When subscribers notify the "Gazette" of Change of Address, would they please indicate whether or not this should be published.

Personal notices are charged at 10p per word (pre-paid, minimum £2.00).

Non-subscribers are charged £2.00 (pre-paid) for all notices other than Death.

GUY'S HOSPITAL RUGBY FOOTBALL CLUB

FIRST FIFTEEN FIXTURES 1978–1979

Date		Time	Opponents	Ground
1978				
September	*2*	*3.00 p.m.*	**Cheltenham**	Cheltenham
	9	*3.00 p.m.*	**Bromley**	H.O.P.
	16	*3.00 p.m.*	**Blackheath**	H.O.P.
	23	*3.00 p.m.*	**Askeans**	Kidbrooke
	30	*3.00 p.m.*	**Stroud**	Stroud
October	*7*	*3.00 p.m.*	**U.S. Portsmouth** ...	H.O.P.
	14	*3.00 p.m.*	**Cambridge University** ...	Grange Road
	21	*3.00 p.m.*	**Old Dunstonians** ...	St. Dunstans Lane
	28	*3.00 p.m.*	**Cinderford**	H.O.P.
November	*4*	*2.45 p.m.*	**Ipswich**	Ipswich
	11	*2.45 p.m.*	**Osterley**	H.O.P.
	18	*2.45 p.m.*	**Old Merchant Taylors** .	Croxley Green
	25	*2.45 p.m.*	**Mountain Ash**	Mountain Ash
December	*2*	*2.45 p.m.*	**Havant**	H.O.P.
	9	*2.30 p.m.*	**Old Millhillians** ...	Headstone Lane
	16	*2.30 p.m.*	**Esher**	Molesley Road

GUY'S HOSPITAL GAZETTE

ANNUAL SUBSCRIPTION

Please fill in the form below and post to :
The Manager, Guy's Hospital Gazette, 16 St. Thomas Street, London, SE1 9RT.
Please enter my name as an Annual Subscriber to "Guy's Hospital Gazette" and send me a Banker's Order Form/or invoice for subscription due. (Delete as necessary).

Name .....

Address .....

.....

..... Date.....

Qualifications .....

Date first qualified.....

If at present working at Guy's please state Department.....

Guy's Hospital Gazette

ISSN : 0017-5870

Tel. No.: 01-407 7600 Ext. 2023

EDITOR	ADRIAN PINI
ASSISTANT EDITOR	PHILIP RAZZELL
NEWS EDITOR	CAMILLA HAW
SPORTS CORRESPONDENT	JONOTHAN EARNSHAW
NURSING CORRESPONDENT	PAMELA JEFFERIES
PHYSIOTHERAPY CORRESPONDENT	RONALD COOPER
MANAGER	PAT POULTER
ADVERTISING MANAGER	JONATHAN BARKER

The opinions expressed in these columns are solely those of their authors and are not to be taken as the views of the Hospital as a whole.

Contents

PASSIM	454
NEWS IN BRIEF	456
CLUBS' UNION NEWS	462
40 YEARS OF MURDER—2 Professor Keith Simpson, C.B.E., M.D.	464
THE CASE OF REGINA v. F. CHRISTMAS John Pini	473
SURGERY—too little, SCIENCE—too much Mr. Frank Ellis	476
INTERVIEW WITH THOMAS GUY Philip Razzell	484
FIFTY YEARS AGO AT GUY'S Mr. R. C. Cann	488
CLOSENESS TO THE PATIENT Dr. S. E. Openshaw	495
A HISTORY OF GUY'S HOSPITAL RUGBY FOOTBALL CLUB—2 Mr. T. L. T. Lewis	497
S.M.E.C.	501
QUODLIBET SOCIETY	502
FILMS	505
NURSING	506
PHYSIOTHERAPY	507
BOOK REVIEWS	508
CORRESPONDENCE	515
SPORT	518
HOSPITAL INFORMATION	524

9 DECEMBER 1978 VOLUME 93 92 NUMBER 2287

Published Monthly at Guy's Hospital, London.

Passim

Merry Christmas!

The *Gazette* wishes its subscribers and student readers a very Merry Christmas and a Happy New Year—thinking particularly of those who will be on duty over the festive period. As you can see our journal has something of a "new look" this month and more changes can be expected in the New Year. Our special congratulations go to those dental students qualifying this month, and we hope that they will keep in contact with the Hospital and their friends by subscribing to the *Gazette* in the New Year!

The Editors.

Union General Meetings

It is unfortunate to have to dwell on unhappy matters in this season of good cheer, but the continuing fiasco of our Club's Union General Meetings cannot go unremarked. The sorry affair organised last month might be better forgotten were it not for the distinct probability of its repetition in the New Year.

Some students see our Union as the forum for raising controversial matters of national politics. This time it was racism, the time before government economic policy. The *Gazette* suggests that important as these matters are they should have no place in the affairs of our Union. Interested Clubs' Union members will already belong to one of the political parties or their affiliated societies in the University, and can there practice to become as famous and witty as Willie Hamilton or the late Sir Gerald Nabarro, but *please* don't practice on us!

A feature of Union meetings this year, apart from the paucity of members present, are the poor agendas. Matters of importance to students are seldom discussed. Changes to the bar just seem to happen, the Spit remains as apalling as ever with never an exciting motion of censure on the Catering Committee, notice-boards and pigeonholes move miraculously without us ever giving the say-so. It is very apparent that the real decisions affecting the Union and its facilities are made at sub-committee level, leaving nothing much for the General Meetings.

Perhaps someone would care to define the purpose of General Meetings, failing which why not scrap them altogether? Perhaps a referendum on this issue might be organised! For its part the *Gazette* believes that General Meetings have an important role in bringing everybody together to discuss Union affairs. Union officers might find that if they produced a sensible agenda enough sensible people would turn up to discuss it and actually reach a decision.

Time for action on the Spit

The pronouncements of food expert Egon Ronay have hit the headlines recently with his survey of hospital catering. It would be a confident Editor indeed who would step into the controversy about why Guy's fared so badly.

An introduction to the Symptoms and Signs of Surgical Disease

Norman Browse

In this book the author describes in detail the relevant features of the history and physical signs of the common surgical diseases in a way which emphasises the importance of the routine application of the techniques of history-taking and clinical examination.

418 pages 298 illustrations Paper £12.75

Multiple Choice Questions in Physiology

—with answers and explanatory comments.

Lynn Bindman, Brian Jewell and Laurence Smaje

Consisting of multiple-choice questions designed to test understanding as well as factual knowledge, the book supplies the answers to these questions and adds explanatory comments. It will be of great value both to teachers and students of physiology.

64 pages 15 illustrations Paper £1.50

Muir's Textbook of Pathology

Tenth edition

Revised by J. R. Anderson

An account of general and systematic pathology suitable for medical students early in the clinical part of the curriculum.

'. . . the revisions have improved this already excellent book and it is now probably the best undergraduate textbook of pathology.'—The Journal of Clinical Pathology.

1060 pages 1016 illustrations Paper £13.75

Clinical Chemical Pathology

Eighth edition

C. H. Gray and P. J. N. Howorth

The latest edition of this long established textbook has introduced much new material in order to keep abreast of the many recent developments in the expanding field of clinical bio-chemistry. It presents a modern survey of chemical pathology in a short textbook suitable for a wide range of medical and paramedical studies.

256 pages 31 illustrations Cloth £7 Paper £3.50

Edward Arnold

41 Bedford Square, London WC1B 3DQ

To many *Gazette* readers the real issue is not so much how the hospital feeds its patients and staff, but how the Medical School feeds its students; a quite separate matter, though apparently a distinction too subtle for Mr. Ronay. It is common knowledge that the food in the Spit has been below an acceptable standard for many years:

"We still queue in both exasperation and anticipation, past the letter rack and the porter's desk to the door. Our reddened Pavlovian mucosa is paled and vanquished by the time we reach the till with a tepid plate and a cold meal. The final insult is dishwater at sixpence a cup. Spit."

"Passim", Vol. 79, p. 93, 1965.

"In all my long experience of eating in similar refectories, I have never been expected to put up with such revolting fare. I have seen canteens at other hospitals which provide much better quality for nearly half the price. The food has a characteristic aroma which I shall remember until my death-bed; I swear if I were led, blindfolded into the Spit, I would recognise where I was by the wave of nausea which its odour excites."

Correspondence, Vol. 85, p. 240, 1971.

"Students at this hospital have a right to good food, in pleasant surroundings, at reasonable prices . . . none of these criteria are being met at the present time."

"Passim", Vol. 87, p. 85, 1973.

To many students the hospital food condemned by Mr. Ronay is a welcome alternative to the Spit, but students attempting to eat in the Tower Restaurant or Nurses Home are liable to be summarily thrown out by Administrative Staff demanding staff identity cards. This is a situation almost inexplicable to our visitors who are not exempt from being turned away, to their surprise and embarassment. In fact the reasons are understandable, for medical and dental students have contributed to large queues in these eating places, where many staff have only a few minutes allowed for lunch. But why do students favour the N.H.S. canteens? The answers have been reiterated and underlined in our columns again and again over the years.

The *Gazette* would be encouraged by any word from the School that students might one day enjoy comparable food to hospital staff at a comparable price. To our knowledge suggestions consigned to the Spit suggestions box rarely receive replies, which indicates the state of relations between the customers and the catering company. This apparently cavalier silence should surely be replaced by dialogue, even if it is rude at first! Our columns are at your service.

News in Brief

The Residents' Play

The 1978 Residents' play will be performed on December 20th and 21st in the Greenwood Theatre, and we hope that many Guy's men

BOOKS FOR STUDENTS FROM CHURCHILL LIVINGSTONE

OUTLINE OF FRACTURES

J. Crawford Adams

1978 Seventh edition 332 pages
117 line and 163 half-tone illustrations
hardback £8.00 / paperback £4.75

NORRIS AND CAMPBELL'S ANAESTHETICS, RESUSCITATION AND INTENSIVE CARE

Donald Campbell and Alastair A. Spence

1978 Fifth edition 276 pages
illustrated £5.00

AIDS TO PATHOLOGY

Michael F. Dixon

1978 264 pages illustrated £3.50

MEDICAL HUBRIS

A REPLY TO IVAN ILLICH

David F. Horrobin

1978 £3.00

A SIMPLE GUIDE TO TRAUMA

R. L. Huckstep

1978 Second edition 264 pages
illustrated £2.95

CARDIOLOGY FOR STUDENTS

Max Zoob

1978 330 pages illustrated £3.95

HUMAN PHYSIOLOGY

Edited by O. C. J. Lippold and F. R. Winton

1978 Seventh edition 540 pages
illustrated £10.50

TUMOURS

BASIC PRINCIPLES AND CLINICAL ASPECTS

C. J. Louis

1978 346 pages illustrated £4.95

AIDS TO UNDERGRADUATE SURGERY

Peter M. Mowschenson

1978 152 pages £2.50

CHURCHILL LIVINGSTONE

POCKET MEDICAL DICTIONARY

Edited by Nancy Roper

1978 Thirteenth edition 406 pages
illustrated £1.20

CHILD PSYCHIATRY FOR STUDENTS

F. H. Stone and C. Koupernik

1978 Second edition 122 pages
£2.25

CLINICAL PHARMACOLOGY

Paul Turner and Alan Richens

1978 Third edition 264 pages
illustrated £2.95

Churchill Livingstone
23 Ravelston Terrace Edinburgh EH4 3TL

and women will come along to be outrageously entertained for the modest sum of 75p. The *Gazette* will be printing the highlights, and as many lowlights as the censor can allow, in January.

New Appointments

We heartily congratulate Dr. Scott on becoming President of the Cricket Club. Mr. Glover, last man in, retires not out and moves on to Chairmanship of School Council.

Messiah

To critical acclaim the Music Club has given two performances of Handel's Messiah in Southwark Cathedral, on the 5th and 6th of December. The *Gazette* will be publishing a full review of this ambitious project in January.

Pupils' Physical Society Meeting

A meeting of the Pupils' Physical Society was held in the Gordon Museum on Tuesday the 28th November. An audience of about 50 students and staff heard masterly presentations by Peter Openshaw on Neonatal breathing mechanisms and by Helen Kinsella on a case of Cystic Fibrosis. Both were well received and enthusiastically discussed.

Any clinical student wishing to present their own research work to the Society should contact Mark Stringer or Alasdair Jacks. The 1978 prize-winning presentation will be announced shortly.

Private hospital inquiry

The plans for a £5 million scheme to convert a warehouse near Guy's into a private hospital, outlined by Mr. Lewis in the May *Gazette*, are to be put to a public inquiry. However, further moves are likely to be postponed until after the next General Election.

Busman's Holiday?

Medical students on Professor McColl's surgery firm are spending a week working as nurses in the Hospital—the latest move in an effort to break down traditional barriers. Unfortunately we will not as yet be able to see our surgical colleagues in uniform, but this may come soon!

New Gazette Manager

The *Gazette* is pleased to welcome to its staff Patricia Poulter, who has succeeded Lyn Payne as our Manager. Pat comes to us from nursing at the Goldie Lee Hospital, South London. She will be in the office on Mondays, Wednesdays and Fridays when callers are welcome.

We wish her a long and happy association with the *Gazette*.

KNIGHT FEVER

another great RESIDENTS' PLAY

in the

GREENWOOD THEATRE

Wednesday, December 20th 8 p.m.

Thursday, December 21st 8 p.m.

Minimum Subscription 75p

Tickets available from Dr. J. A. Vale,
Boland House, Guy's Hospital, SE1 9RT
On sale in the Colonnade from 12th December.

The Evelyn Sprawson Prize

Our warmest congratulations go to Jane Taylor who was awarded the Evelyn Sprawson Prize for 1978.

The prize, awarded tri-annually for the candidate awarded the highest marks in each exam of the LDS, was instituted in 1959 to commemorate the centenary of the Charter which led to the Establishment of the Licence in Dentistry.

Guy's recipients of the Evelyn Sprawson Prize since 1959:

1959 G. M. Edwards
1960 M. L. Maberley
1961 J. L. Williams
1962 G. W. Cooke and R. Boggan
1963 J. D. Gullan-Whur and R. P. Juniper
1965 R. G. Johnston and C. D. Stephens
1966 Miss P. A. Hubbard
1968 D. S. Lewin
1969 Miss E. J. Waterhouse and P. W. Lambden
1971 P. O. Robinson
1972 N. W. T. Harradine
1974 R. J. Ibbetson
1975 G. A. Irvine
1976 C. J. Campbell
1978 Miss J. E. Taylor

Notice

CHRISTMAS 1978 IN THE HOSPITAL CHAPEL

Tuesday, 12th December at 7 p.m.

THE CHRISTMAS CAROL SERVICE.

Sunday, 24th December at 11.30 p.m.

THE CHRISTMAS MIDNIGHT EUCHARIST with carols and the Blessing of the Crib.

Monday, 25th December—Christmas Day

8.30 a.m. HOLY COMMUNION.

10.30-11 a.m. A CHRISTMAS MORNING SERVICE.

Wednesday, 27th December—St. John

1.15 p.m. HOLY COMMUNION.

Lambeth & Southwark Division of The B.M.A.

Annual Dinner 1978

The Annual Dinner of the Lambeth & Southwark Division of the B.M.A. was held on 23rd November in the Robens Suite, Guy's Tower. Nearly sixty members, wives and friends were present to hear Dr. K. S. MacLean's oration entitled, *"Forty Years at Guy's"*. The speaker gave a nostalgic and highly personal view of his career at Guy's which was both witty and interesting. Anecdotes and reminiscences flowed thick and fast and a thoroughly enjoyable evening was had by all.

Consultants – G.P.'s Annual Meeting 1978

Held in the Robens Suite on 8th November when four papers were presented. Dr. Clark spoke on "Haemoglobinopatines", Dr. Cook on "Primary Care in Rhodesia", Professor McColl on "Medical Audit" and Major General Rogers on "Guy's Casualty". The *Gazette* will be publishing these four papers from January through until April.

DISTRICT REPRESENTATIVES

Guys Mr. W. D. C. OWEN
St. Thomas's Dr. P. MEISNER
Kings Dr. W. F. WHIMSTER

EXECUTIVE COMMITTEE

Dr. A. C. ALLEN
Dr. A. R. ANDERSON
Dr. H. BINYSH
Dr. T. A. V. BROOKS
Dr. C. J. W. CLAYDON
Dr. E. M. HICKEY
Dr. H. JAMES
Dr. N. D. L. OLSEN
Dr. S. SLOVICK
Dr. A. A. N. VIRJI

B M A

LAMBETH & SOUTHWARK DIVISION

1978-79

President:
Professor IAN McCOLL

Hon. Secretary:
Dr. E. M. ROSSER,
6 Drummond Rd., S.E.16
01-237 7180

Hon. Treasurer:
Dr. J. A. GAVIN

PROGRAMME FOR 1979

Sun., Feb. 25th THE ANNUAL HALF-DAY SYMPOSIUM
10.00 a.m.— to be held in the
1.00 p.m. Anatomy Theatre of the Medical School at Guys Hospital.
Subject: "What's New in Medicine?"

Wed., April 11th THE ANNUAL GENERAL MEETING
6.30 p.m. to be held in the
Anatomy Theatre of the Medical School at Guys Hospital.

Other meetings will be held as and when necessary.

Clubs' Union News

Attempts to change the constitution again

After nearly eighteen months of earnest discussion some constitutional proposals will be going to the Annual General Meeting on February 8th next year. These are outlined below in detail.

In formulating this third draft I have been guided by several points. They rest on the conviction enunciated by the DES "that it is an important part of the educational process for students to manage their own affairs". You will see that these proposals will not give the students complete autonomy but they will manage a few more of their affairs than before. It would, in my opinion, be dangerous to move from a position where students only carry a small part of the workload, to one where they carry all the workload and are expected to use knowledge they do not possess. So the proposals are in a sense a half-way house. But it is unrealistic to think that staff will contribute their knowledge and experience to the Union if they are given no vote and the Union is considerably better off with their knowledge and experience than without. So the staff all have a vote and an important one at that.

The changes themselves

1. There are a few rules which have been updated, for example the Boxing Club and Art Society no longer function. In their place we have the Badminton Club, Community Action Group, Gilbert & Sullivan Society, Issues in Health Group, University Medical Chaplaincy and Women's Swimming Club.

2. In the place of the Book Exchange is the Union Shop. This shop sells Guy's sweat shirts and T-shirts and in the future hopefully Guy's ties and cufflinks etc. It will be run in the same way as the Book Exchange was run.

3. There is a need on the Union for two people to cope with external affairs, one a medic and the other a dentist. Each would be a Vice-President, eligible for re-election and the medic would sit on SMEC *ex-officio* and the dentist on the Dental Society management committee. Their roles would be mainly concerned with expertise in the fields of education, both internally and externally. One of the Vice Presidents would be elected to deputise for the President and one would attend School Council with the President. This being the case, there would be no need for the post of Ordinary Member.

4. The notice required for an Extraordinary General Meeting needs to be reduced to 7 days from 14 days.

5. It is my opinion that the chair at General Meetings should be taken by the President just as the Bar Committee should be chaired by the President. The role of the Union Chairman would be to chair the Council meetings.

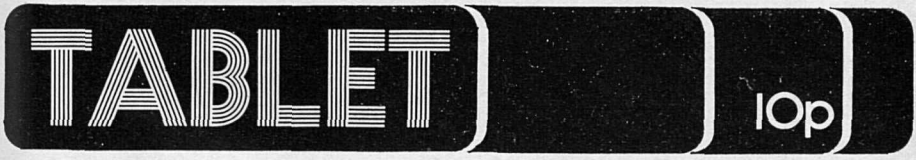
6. The most significant and far reaching changes are with regard to the administration of the Union. In principle the students should run their own affairs and this is most important in terms of administration. Therefore I have proposed that the responsibility for the administration

of the Union should rest with the Junior Secretary not the Senior Secretary in all matters except the elections and the Bar Licence. He would then sit on all the committees of the Union and would effectively become the President's right hand man. This may help ease the burden on the President as well.

7. In an effort to raise the status of the Junior Secretary and Junior Treasurer the term Junior should be abandoned and the term Senior replaced by Honorary. We would then have an Honorary Treasurer who is a member of the Senior staff, an Honorary Secretary who is a member of the Junior staff and a Secretary and Treasurer who would both be students.

8. In an institution such as the Club's Union, we feel that Standing Orders ought to be introduced and employed when necessary. These are based on the Standing Orders used at the University of London Union.

DAVID DENNING.



THE RAG FOR ALL WHO TRAIN AT GUY'S

STOP PRESS

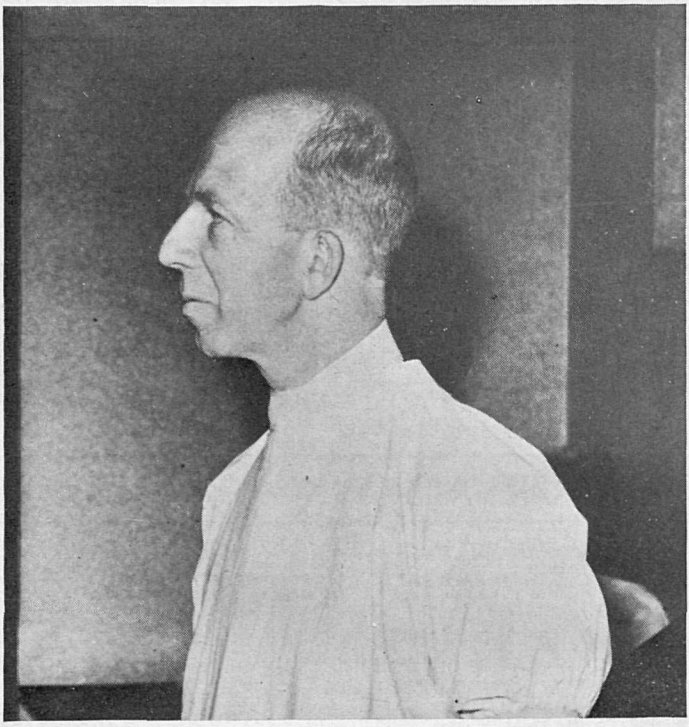
(for our subscribers 'Tablet' is a student newspaper at Guy's.

We wish them a Merry Christmas !)

40 Years of Murder - 2

by PROFESSOR KEITH SIMPSON, C.B.E., M.D.

(Following the tremendous response to last month's article, Professor Simpson has kindly agreed to our request for further excerpts from his autobiography which is published by Harrap at £6.95.)



Keith Simpson, as many Guy's men might remember him—in the mortuary.

HANRATTY AND THE A6 MURDER

A famous shooting case that came on my files later was the murder of the young road research scientist Michael Gregston, in a lay-by off the A6 road in Bedfordshire in the early hours of 23rd August 1961. It was that rare thing, a murder in full view of a third person, for Gregston was accompanied that night by an attractive young laboratory assistant, Valerie Storie, who not only saw her boy-friend killed but was herself then raped and nearly killed. The case went down in criminal history as the "A6 Murder", a prosaic name for it considering the crime took place on an isolated stretch of the A6 that already bore the more sinister name of Deadman's Hill.

According to Valerie's version, and there was no other, a man had surprised them when they were parked in a field near Windsor after dark, chatting in their car. He had tapped on the window, and when it was lowered poked a revolver in, saying, "This is a hold-up". He got in the back of their car and, at gunpoint, forced Gregston to drive along a route he dictated for over three hours. Finally he ordered them into the lay-by on Deadman's Hill, near Clophill. It was then about 3 a.m. "I want to kip," the man said. "But first I must tie you up." He tied Valerie's wrists with a piece of rope, and looked for something to use for tying Gregston, still in the driving seat. "Give me that bag up," the gunman told him. Gregston was turning to obey when the man fired two shots at his head in quick succession from a very close range.

Valerie screamed. "You shot him, you bastard! Why did you do that?"

"He frightened me. He moved too quick, I got frightened."

She begged him to let her drive Mike to a doctor. His reply later formed a vital clue to Valerie's identifying him:

"Be quiet, will you? I'm finking."

A few minutes later he repeated the word "finking". Then he ordered Valerie to get into the back of the car with him and take off her

General view facing South showing position of body. The R.A.C. box can just be seen at end of "layby".

knickers. She refused until he threatened to shoot her, and then she obeyed and submitted to rape. This was quickly over. He told her to get out of the car and help him remove Gregston's dead body. He made her show him the gears and start the car for him; and then, from about five to six feet, as she sat on the ground weeping, he shot her five times in rapid succession.

Leaving her apparently dead, the man drove off. Valerie lay there, paralysed in both legs and only semi-conscious, until a farm worker discovered her at about 6.30 a.m.

I went first to the scene, as I always did, to join the police team in their initial survey, then later drove on to Bedford Mortuary. From the fall in temperature, rigor mortis, and other conditions I estimated that Gregston had died between 3 and 4 a.m. He had two .32 calibre bullet wounds of the head, shot "through and through" from left ear to right cheek. The skin was tattooed round the entry wounds, and the range could not been more than an inch or two; the shots had evidently been fired in rapid succession, before the head had moved.

On the following Sunday I went across from my Tring house to Bedford Hospital to examine Valerie Storie. She had similar calibre through-and-through wounds, one of the neck and four drilled-in holes in over her left shoulder and down over her arm. I thought probably all five shots, which were in a line, had been fired in quick succession and from beyond arm's range. She was lucky to be alive and would have been luckier had not one bullet transfixed her spine. "I felt the use of my legs go," she said to me. Sadly, this attractive girl never walked again.

When I saw her in the Bedford Hospital ward Valerie was over her initial shock and half sitting, propped by pillows, quite bright and able to chat. I did not ask what had happened, but said I had come to examine her wounds in order to help the police with their reconstruction. "I am a Home Office pathologist," I said, "but I am also a doctor." She smiled as the ward sister helped her remove her bed jacket, and made no fuss when I took several 35 mm "flash" colour stills of her wounds. But only her face and arms moved: her legs were paralysed. I felt (as I often did) more disturbed at this tragic sight in a living creature than by a dead body.

I was impressed by her intelligence and her very clear mental state so soon after her frightful experience. Her account of the rape and of the shooting of Gregston and herself was borne out completely by my medical evidence. I was impressed too by her courage, for obviously she had to overcome great emotional stress to be able to talk about it as calmly as she did. She did not cry.

A few days afterwards Valerie was transferred—as it happened, to my own Guy's Hospital. She was still there three weeks later, when the police announced in the press and on television that they wished to interview a man named Peter Louis Alphon, who they thought might "help them with their inquiries"—their usual euphemistic way of saying who was suspect No. 1. On 22nd September the appeal was answered by Alphon himself, and he was taken into custody. Not yet having enough evidence to charge him with the crime, the police came immediately to

Guy's in the hope that Valerie was fit enough to attend an identification parade.

They could hardly have come at a worse time, for Dr. Rennie was in the process of removing two bullets from her body. He sent the police away, and again refused them the next day; but on 24th September he gave way to their pressure and allowed his patient to be wheeled out on a bed to face a line of men and try to pick out the one who had killed her boy-friend Gregston and shattered her own young life. "She was not flustered and was quite clear in her mind," Rennie testified afterwards, "although she was very keyed up and tense." The conditions were far from ideal.

It was a peculiarly harrowing ordeal for Valerie: describing the crime to sympathetic doctors and policemen was nothing like so distressing as the prospect of looking again into the face of the man who had defiled and shot her. Further, as often happens at an identification parade, there was considerable police anxiety—mostly unspoken, but keenly felt—for her to pick out the man. The police believed they had the right man, they had spent a month's hard work on getting him there, her identification was vital to the evidence, and they would be disappointed if she said she could not be sure and they had to let him go.

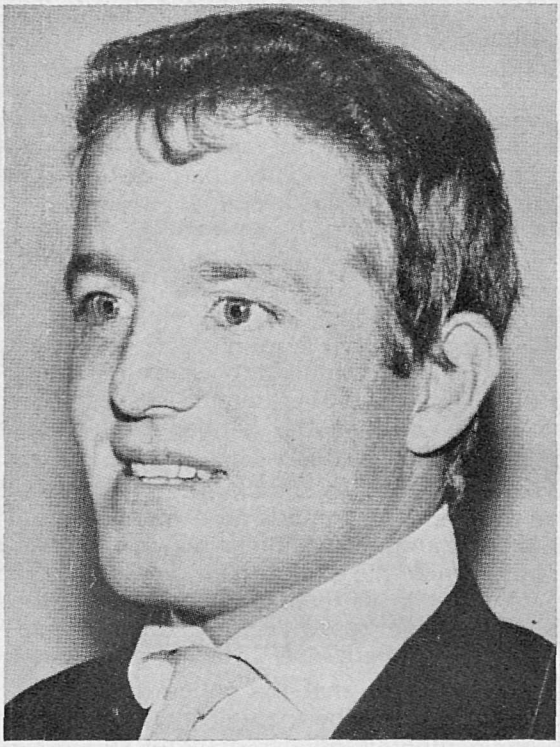
She was still far from well and probably very vulnerable to such pressure: it probably ought not to have been imposed. But nobody can deny that that parade was conducted with scrupulous fairness. For Valerie Storie, in her somewhat emotional state, and eagerness to "get it over", spent only five minutes on her examination of the parade before picking out a man who was not the suspect Peter Louis Alphon but a Spanish sailor, one of the similar but indisputably innocent "controls".

Alphon was released from custody, and Detective Superintendent Acott said later that he now "knew where Alphon was" on the night of the crime and for that and several other reasons he was satisfied of his innocence. It was a pity the police had pressed for an identification parade before Valerie was fit for it. It seems that if they had waited a little longer it would have become clear that they had got the wrong man: Alphon was "somewhere else". He led a curious life.

It was unfortunate, too, that the police did not tell Valerie before the parade that she could, if she thought it would help her, ask the men to speak. She would undoubtedly have done so, for, as she had said from the start, she had seen the murderer's face in good light only once, and then briefly, but she had heard his voice for six hours. He had, as she had already told the police, a distinct cockney accent; she remembered particularly that instead of "things" and "think" he had always said "fings" and "fink". She would hardly have made a mistake about the Spanish sailor if she had heard him speak.

The day after the parade Valerie was transferred to Stoke Mandeville, the unit in Buckinghamshire that specialized in rehabilitating so many spinal-cord injury victims. The treatment was psychological as well as physical, and there is no doubt that from the day she entered Stoke Mandeville her emotional state improved. Meanwhile Acott had received several telephone calls from James Hanratty, for whom a search was going on: he was located in Blackpool and arrested.

Three weeks after the identification parade Valerie was asked to attend another. This time she asked if she could hear the men speak. There were thirteen on the parade, and she scrutinized them for twenty minutes. She was wheeled up and down the line several times, and asked each man to say "Be quiet, will you? I'm thinking." Each man had to say it twice. Finally, without hesitation, she picked out Hanratty, the man who had by then become suspected by the police much more strongly than Alphon had ever been. Hanratty was the man whose "th's" tended to be "f's".



Mr. James Hanratty

The trial of Hanratty at Bedford Assizes lasted twenty-one days, becoming the longest in English criminal history. Mr. Justice Gorman was meticulously patient and fair. Naturally the defence made the most of the fact that Valerie Storie had picked out another (and certainly innocent) man at the first identification parade; and Hanratty's counsel, quick-witted Michael Sherrard, Q.C., had no difficulty in showing that the Identikit picture constructed from Valerie's information did not look much like the man in the dock. (It seldom does.) Indeed, when it was displayed for the jury to see there was a murmur of talk and even a few smiles, for the only resemblance it really bore was to the clerk of the court who was holding it up! But Valerie was an admirably cool, impres-

sive witness, and I watched her survive a hard cross-examination unscathed. Hanratty was found guilty of murder, sentenced to death, and hanged.

Michael Gregston was dead and Hanratty was dead, but the ghost of the A6 murder has lingered on. Alphon wrote a "confession" for a friend, Jean (John) Justice; more than a hundred Members of Parliament (including two former Home Secretaries) signed a petition for an inquiry into Hanratty's conviction; and at least three full-length books (respectively by Louis Blom-Cooper, Lord Russell of Liverpool, and Paul Foot) have questioned the jury's verdict. But no-one engaged in the case, as I was, and entirely disinterested in the innocence or guilt of the accused, as every pathologist should be—and I certainly am—could fail to be impressed by the weight of the evidence. Not only the calm Valerie Storie, but two other witnesses confidently identified Hanratty, and none of these three was shaken by cross-examination. I myself do not doubt that the Crown case has in no way been seriously dented by the books and articles written on the case.

STRANGLING AND SUICIDE

Spilsbury, typically solitary, never had a secretary, and of course a pathologist who dabbles in crime is hardly the kind of employer every fond mother would think of for her darling daughter. Noel Coward might well have coupled it with the stage in his advice to "Mrs. Worthington". Deaths, dismemberment, dirty hovels, ditches, dried-up infants in lockers or suitcases, drunks, the sort of clinging smells that cause your boy-friend to go off you, late hours, constant pressure: it needs an unusual type of girl to "go the rounds" with this sort of doctor. Molly Lefebure, my first secretary, came to me from journalism, and when she left me five years later, to get married, she wrote up her experiences in a fascinating book, *Evidence for the Crown.* Young, blonde, lively, and amusing, she was with me for most of the war, and never seemed to have time for reflection on the disadvantages of working for a man who always seemed to have got his hands on some malodorous body in a mortuary, who never seemed to notice the time, who was mad at secretaries who got colds, and who didn't on the whole agree with "time off".

One of my favourite relaxations when living alone in London in wartime was wining and dining in Soho with close colleagues and talking shop. I used to meet my two London contemporaries, Francis Camps and Donald Teare, regularly at the French restaurant L'Etoile, in Charlotte Street, where good food and wine were still available in spite of shortages and rationing. Nino, the proprietor, had devised a substitute for the dry Martinis and Pernods of peacetime, a powerful aperitif which he called "ARP" (wartime short for Air Raid Precautions) which consisted of absinthe, rum, and paregoric—or so Nino said. A shot or two of this certainly helped to restore our flagging spirits!

We had little contact with our elders—Spilsbury, John Taylor, or the Home Office analysts of the day, Roche Lynch and Ryffel. They were much older, and seemed to have little or no interest in living outside their official jobs, unless it was to browse in their London clubs. But Eric Gardner, the Surrey pathologist, would sometimes join us, chauffeur-driven in his sleek blue Railton, to pull out of his capacious greatcoat the last " 'orrible specimen" or a few skeletal remains, rather

as L'Etoile might produce the *plat du jour.* Occasionally, also, I might have a call from Dr. Grace, the Home Office pathologist to the Chester and Liverpool area, to talk over some problem; but he preferred the spacious Euston Hotel, now alas pulled down, since he could walk straight out on to the Stygian gloom of the adjacent station platform to catch his night train home with the hundreds of service men and women who were daily being "posted" somewhere.

Our complaint of the Euston Hotel was that too much notice was taken of air-raid alarms, and also that there was no place of privacy in which to produce a piece of bloodstained clothing or a mangled larynx, or even the latest "filthy" pictures of some new crime we wished to show each other.

One evening Gardner and I had an argument in the Euston Hotel that led to an experiment which I recalled years later, when taking part in a radio programme on the pros and cons of capital punishment. Someone on the panel had said hanging was painless, and added that the victims of murders did not usually die so easily. I retorted that strangling was not very painful. Ears were pricked up. The B.B.C. interviewer said, "How do you know Doctor? Have you ever been strangled?"

"Well, yes, almost . . ." I was thinking of that evening with Gardner in the summer of 1941, in the Euston Hotel.

Our disagreement was over the death of a woman named Marjorie Fellowes, who had died of asphyxia due to strangling. Gardner, who had performed the autopsy, said she could not have done it herself, and the Coroner's jury had returned a verdict of murder by some person or persons unknown. The only person who had had an opportunity to kill her was her husband, with whom she had been on bad terms. The police had found no other evidence against him, and the Chief Constable had asked me if I would review the medical evidence as to whether it justified a charge of murder. Or was it possible that she had committed suicide?

Most strangling is done with the bare hand or hands, and that, of course, is always murder. It is physically impossible for a person to strangle himself manually because as he begins to lose consciousness he will inevitably relax his grip and so recover. But in the case of Marjorie Fellowes a ligature, a silk stocking, had been used. It had been wound *twice* round her neck and *knotted twice.* At his p.m. Gardner had found clear signs of asphyxiation, and he did not think she could possibly have had the time before losing consciousness to tighten the ligature herself.

"You may be right about that," I said, "but I believe she could still have managed to strangle herself." It was a question of time, really.

Her husband had said he heard her coughing at 2 a.m., very close to the estimated time of death. Gardner had found quite a lot of undissolved veronal in her stomach; not perhaps a lethal dose for a healthy person, but she had been riddled with tuberculosis and was already showing signs of heart failure. Nobody doubted that she had herself taken this obvious overdose either by accident or, more probably, with suicidal intent, and it seemed quite likely that she had taken the drug shortly before she tied the ligature. The drug would have caused venous congestion and swelling of the neck, which could have increased the strangling tension of the ligature.

Gardner then objected that she still could not have tied the double knot (a reef). The stocking was too short for her to have remained conscious long enough after looping twice and tying one knot to be able to tie a second. He had brought the stocking with him, and we measured it. It could be stretched to 46 or 48 inches. The circumference of her neck was 13 inches. Twice round would be 26 inches. That left 10 to 11 inches for each end, and I thought this quite enough. "No one with a neck measurement of 13 inches could do it," Gardner insisted. I asked him to measure my neck. At the level in question it was exactly 13 inches. I looked for some privacy in the lounge of the Euston Hotel: hopeless. I could think of only one place that offered the necessary seclusion. . . .

We went to the men's toilets, both got inside one and, locking the door, turned to our experiment. I wound the stocking twice round my neck, tightly, and set about the tying of a double knot before (I hoped) losing consciousness. Blue in the face and already seeing things a little mistily, I succeeded, *and* got the tie loosened before getting enough breath to gasp "How's that?"

How very foolish we both were neither of us had for a moment contemplated: quick tightening of a hand or a ligature round the neck can kill like a karate chop—suddenly, of reflex vagal nerve stoppage of the heart action. Next morning's papers might well have carried the headlines:

KEITH SIMPSON FOUND STRANGLED IN HOTEL TOILETS: NOTED PATHOLOGIST HELD ON SUSPICION

or

MYSTERY OF HOME OFFICE PATHOLOGIST'S SUDDEN DEATH: TWO IN LOCKED MEN'S TOILET AT LONDON HOTEL

It was only when we both crossed the corridor to the hotel bar that the real stupidity of our act began to dawn on us. We had to laugh, but my point was made, and no charge of murder was brought.

I never tried that again; but a colleague in the Midlands attempted to repeat my experiment, collapsed, and was saved by prompt police action.

The case of Marjorie Fellowes was unusual but not unique. Other cases had been recorded of self-strangling with a ligature. Yet in my first twenty-five years of medico-legal practice I saw only three such cases, including Marjorie Fellowes; and as I had by then seen some 40,000 cases of all kinds I thought it must be rare indeed. Statistics can be misleading; for in the next year, in another 2,000 post-mortem examinations, I saw three more. This encouraged me to write a paper on all six cases for the *International Criminal Police Review,* the organ of Interpol; in the hope that it might help world police officers to avoid error and injustice.

Three of my six cases plainly admitted no other interpretation but suicide. In one, a woman of seventy-two had wound a thin rope round her neck, tightly enough to constrict the veins, *eighteen times.* There was no knot, both ends lying loose in front. Her husband was gravely ill in hospital, and she had threatened suicide.

Another woman, aged fifty-seven, had made a cord noose with a slip knot which she set under her left ear; then she pulled the loose end tight round the back of her neck by holding the cord wound round her right hand. This was a remarkable case, for her husband was trying to stop her. She had woken him in the night, moaning and crying, and had swallowed a carton of sleeping tablets, about thirty-two of them. Then she had left the room and returned with the noose round her neck. Her husband had managed to loosen it, but she was stronger and, standing by the bed, set it again and strangled herself, collapsing on the floor. He had then tried to loosen the ligature again before she died, but without success. Finally he had gone into another room and attempted to gas himself, but was discovered in time. His account of the incident was verified by the way the ligature was held and by the finding at autopsy of a substantial overdose of sleeping tablets in the stomach.

The third plainly suicidal case was of yet another woman, a recluse of sixty-five, who was found dead sitting in a chair. A cord ligature was set round her neck in a single loop, and a half-hitch held it on the left side under the ear. She had placed a pencil between this half knot and a second hitch so as to make a tourniquet, twisting the pencil several times and finally holding it in position with one end under the jaw and the other stuck into the neck above the collar bone. In a similar case that occurred some years later, a man had tightened a noose of ordinary string by passing an umbrella handle through the loop and twisting it around at the back of his head. It is probably unfamiliarity with this method that has led historians to suspect Napoleon I of the murder of General Pichegru. The general was found strangled in prison by a ligature that had been tightened by means of a stick, which had been twisted and then fixed behind one ear; there was no lividity of the face. The evidence for homicide was very weak, and the suggestion that the ligature had been added as window-dressing after he had been strangled or suffocated seems very far-fetched.

The other three cases I described for Interpol were more intriguing because they were hardly distinguishable from murder. One was Marjorie Fellows. In another a woman of eighty-two was discovered lying peacefully in bed in her night attire with her head on a pillow, face upward, and a stocking round her throat, looped twice, tightly, and held tight by a single half-hitch in front. Only minor asphyxial changes were present, and at the autopsy many capsules of amytal, partly dissolved, were found in her stomach. Evidently she had swallowed poison and, not dying at once, had set the noose round her neck. It was tight enough to constrict but had added only a little to the course of events leading to her death. There was no disturbance in the room, and the door was locked on the inside with the key still in the hole.

The most sinister-looking of my six cases was of a Berkshire woman of seventy-three, known to be suicidal, who was found by her son lying dead on her bedroom floor. A piece of string encircled her neck tightly twice, and was tied by a double knot under the right ear. A minor injury to her right index finger had bled slightly, soiling the carpet. The consequences for her son would have been less unpleasant if he had acted like a good detective and not touched the body until the pathologist arrived. Instead he had acted like a son, loosening the knot and releasing the ligature, and trying to bring his mother back to

life. Neither the local police nor their pathologist had had such a case, and they were uncertain whether such a self-strangling could ever be suicidal. Fortunately I was able to clear him of suspicion. The woman's dentures lay on the floor close to her face, and I thought probably she had strangled herself whilst sitting on the bed and had toppled off, injuring her finger in her fall.

The Case of Regina v. F. Christmas

by our Crime Reporter, JOHN PINI

The Defendant, one F. Christmas, who was charged in his real name of Nicholas, was ordered to be strung up by the sleigh-bells after being found guilty and previously being bailed in his own recognisance of 3½p at the Greenland Crown Court today.

His Honour, Judge Twinfeet, mounting the bench, expressed horror at the extent of the charges against the defendant and did say, though *obiter*, that he made Ronnie and Reggie Kray look like Bill and Ben.

A Detective Sergeant gave evidence of finding the defendant firmly wedged down a chimney in Dollis Hill and promptly apprehended him on suspicion of aggravated burglary and criminal damage. He was *now before the Court and on the first matter of trespass, Prosecuting* Counsel noted that the offence was one "committed annually against most of the homes in the British Isles, entry being effected through the chimney." Defendant then asked for some 13 million similar offences to be taken into consideration and his defence, that people invited him by leaving notes up chimneys, was dismissed as virtually contempt of court. His other defence, that he was a victim of historical circumstances was dismissed by His Honour on the grounds of some existentialist argument propounded by an obscure Frenchman whose name he couldn't recall (was it Satire?).

Twinfeet, J. says he will not be harassed

Mr. Traverse for the defence said at the outset that he wished to enter four *caveats in feodo* and claim other relief; and he further urged that the Crown were estopped from instituting proceedings by virtue of an implied licence to Christmas if not "downright encouragement." Twinfeet, J. deliberating said he would not be harassed by silly petti-foggers and the matter would proceed forthwith.

The charges

Christmas was then further charged that on 25th December, 1978 and at places too numerous to mention "you did cruelly over-drive and over-load a party of animals, more precisely that you did cause 55 million tons of assorted goods to be drawn by 6 quadrupeds known by the name and style of "Reindeer" contrary to S.1 of the Protection of

The defendant, F. Christmas, behind bars at Guy's Hospital.

Animals Act 1911.* This was particularly dastardly observed Twinfeet J, since the situation should never have been allowed to materialize—*the Reindeer should have been quarantined. In that total state of gravity* known as "all seriousness" His Honour was "aghast" at the Defendant's "utter disregard" for the reindeer. It was further noted by the Court that 6 animals and a sleigh hardly met the criteria of airworthiness laid down in Part III of the Air Navigation Order, 1976 but this matter was dropped.

Flagrant Contravention

However, noted prosecuting counsel, Mr. Hatchblade, the defendant was charged with being in flagrant contravention of the Civil Aviation Act 1971, in that he lacked a licence for the carrying of cargo and his defence that the licence was created by conduct was dismissed by Twinfeet J, who said that he (His Honour) had done nothing that would imply the existence of a licence. Notwithstanding this, defendant had failed to keep a log-book as required in law; Twinfeet J observed that there was far too much of this type of thing in Dollis Hill and "*juridicial obscurantism will not stand in the way of my imposing a* swinging sentence. Proceed Mr. Hatchblade."

An arsenal of weapons

Turning to the grave matter of incitement to commit a crime, the police had taken into their custody a quantity of plastic machine guns, knives, swords, halberds and a consignment of bomb-making equipment apparently constructed out of stressed cardboard. Mr. Hatchblade noted *the early case of R. V. Gregory (1867) and argued that there was clear* incitement to the "youth of our fair Isle" to embark upon a course of "death and destruction" of "aspect unendearing".

Counsel for the defendant asked for proceedings to be stayed and a writ of *certiorari* and/or *mondamus* entered and an action for *replevin, garnishee* proceedings and other relief to be entered. Twinfeet J, said that in a distinguished judicial career he had never heard such "baubles" in all his life. "Proceed Mr. Hatchblade."

Hatchblade continued in sombre tones and in his submission there were other matters outstanding against "the recidivist Christmas" not least of which was his marked propensity to fly too low and, hence, too near to rooftops.

The ancient habit of leaving him a glass of sherry at each call left him unfit by reason of drink to be in charge of a vehicle, but again this matter would be dropped. He urged the court to note that the spirit of the Sex Discrimination Act was openly flouted and urged upon the defendent the appelation "Christmas Person" in all his future dealings with the public (limited though they would be after today's proceedings were over).

The matter of interfering with little boys in a cotton-wool lined booth in Harrods was dismissed as was the fact that he was an illegal immigrant.

The matter of Deistic impersonation, at least as far as omnipresence was concerned, was a matter best left for "the highest court in the . . . (Hatchblade paused) . . . land."

*Apparently some of the animals had wings or at least could ambulate themselves with considerable agility.

Christmas found guilty and sentenced

Twinfeet J, in passing sentence, merely referred to "this odious personality who, under the guise of altruism, annually terrorised this land" and he hoped that the barbaric practice of celebrating Christmas, which was in reality a Pagan sun-worship ritual, would cease."

Sue, Grabbit and Run for the Defendant } Instructing
Plead, Swear and Bullshit for the Crown } Solicitors

SURGERY – too little, SCIENCE – too much

Part of the Presidential Address delivered by Mr. Frank Ellis to The Medical Society of London on Monday, 9th October, 1978.

"The George Doherty's of the Profession had neither the time nor the inclination . . . to counteract the inevitable consequences of the grey men of Socialism."

I am going to comment on the present position of general surgery in relation to the rest of the profession, and to the wider aspects of health care. From the title you will see the general trend of my thoughts at the outset.

As a starting point take Guy's Hospital in 1948 and a consultant surgeon on the staff, Mr. George Doherty. He was an accurate diagnostician, a master craftsman and a man of wisdom. The hospital was relatively small, ran like a sewing machine under the general guidance of the Board of Governors and a committed workforce, intensely proud of its activities and sparing no effort for the wellbeing of that now almost totally neglected excrescence of the Health Service—the patient. George Doherty knew all his colleagues well, saw most of them every day and was entrusted with the position of Superintendent of the Hospital. As such he and the Dean of the Medical School forged a leadership which made everyone in the hospital feel that his problems were heard readily, dealt with fairly and accepted the decisions made without question.

What point has the surgeon comparable with George Doherty reached today? Have we anyone in a position of authority in the hospital, readily able to grasp and understand fully the knowledge necessary to run the hospital? Have we anyone with time to think and to hear, gaining profit and pleasure from the most important duty of all —the care of his patients? Unfortunately the complexity of the administrators' role makes it virtually impossible for the necessary tasks to be carried out by one person, even if he were to cease completely to take part in patient care!

I shall examine some of the developments occurring during the past thirty years and thereafter suggest some changes in direction which might assist in the restoration of a more acceptable position. I believe that the decline in the number and status of general surgeons has resulted from a number of factors, the principles underlying which seem perfectly logical but which have failed to work in practice. Because of their apparent logic I have chosen to group them together as "Sciences" although they cover a broad range of activities.

Politics and Surgeons

It is of course a matter of great regret that I have to refer to political issues first. It may be entirely unacceptable to more Senior Fellows who were moulded into a profession at a time when its practice was entirely independent of such issues. It may even be a matter of surprise to some students because their enthusiasm is entirely taken up with medicine. However, they should realise that as long as the present system survives *politics* will play a dominant role in their careers. What has been the effect of political decisions on the general surgeons? In this area they suffer, in common with their colleagues in all disciplines, a status so diminished that their voices are barely heard. It is a situation which arose because they moved too late to counter the wily manoeuvres of the politicians who since the inception of the National Health Service have succeeded in reducing their role to middle management. The George Doherty's of the profession had neither the inclination nor the time, nor the cohesion necessary across the nation to counteract the inevitable consequences of the actions of the grey men of Socialism.

In 30 years the National Health Service has struggled to fulfil the nation's expectations but we are constantly having situations in which the lives of patients are put in jeopardy by compromising minimal

medical standards. The profession's commitment to the Health Service and high standards has been eroded beyond measure. Even young doctors who have to some extent fought the systems far more effectively than their elders, are disenchanted. One of them writes: *"The thought of 30 years' underfinancing, disincentive to work, long waiting lists etc. before I can draw an index linked pension is both hopeless and unworthy."* But how many doctors have simply given up and are now counting the years before they can get out. I suspect a very large number and I think it will go down in history to the shame of the general surgeons, that they, who should have become the most powerful voices in the profession, in the main stood by and watched it all happen, and of course I include myself as having contributed to this state of disarray.

Administration of the N.H.S.

The administrative maze is entirely impenetrable to the average doctor. Successive Governments have pushed the Profession down the economic scale but none more so than the Joseph re-organisation of 1974. Deliberately devaluing skill, training and responsibility has gravely affected other associated health professions. In the new organisation of the National Health Service the clinical supremacy of the doctor is at risk—just a member of the health care team. The rise of union power, creation of Community Health Councils and local government involvement have brought everyone into the decision making process. Everyone wants a finger in the pie, professional opinion has little weight and the primacy of the patient has ceased to exist. The medical profession, most of whom have neither the inclination nor the background will have to devote time to the learning and practice of politics if their views are to be effective.

Community Health Council

My own most recent unpleasant experience came in the form of a four-page letter from the Secretary of the Community Health Council who wrote concerning complaints from a patient about his management in hospital. Amongst the complaints was reference to an incident in which prompt action by my House Surgeon saved the patient's life. What happened in fact was that the patient had a brisk haemorrhage from an arterial bypass in the thigh. My House Surgeon stopped this by re-opening the incision and applying digital pressure. Here is the Community Health Council comment *"This action . . . could have been fatal"*. Of course such an inept statement arises only through gross ignorance. It should be the subject of laughter but in fact the reaction throughout my team was gross loss of morale. We went through a phase of protecting ourselves against similar allegations by not operating on patients who might have benefited from vascular reconstruction. This balance between a decision to operate in the face of a known risk or to leave the disease to pursue its course can be much more difficult than many realise, boldness in surgery whilst all too readily misinterpreted as unnecessarily aggressive, can be life saving. The Medical Defence Union informs me that the profession has no redress against any of the statutory powers of the C.H.C.

Financial cutbacks

A Health Service based on the wrong concept and run by the inept can result only in financial disaster. Despite the bleats about a low percentage of the Gross National Product being devoted to health care, I believe much of the shortage in vital sectors is due to mistakes in allocation of resources. No one has written more formidably about the fallacies of R.A.W.P. than Sir Francis Avery Jones, in the British Medical Journal earlier this year.[1] As a model for the National Health Service the R.A.W.P.[5] formula is not very good, in fact the Radical Statistics Health Group have demonstrated that the published formula is nonsense.[4] Applied to London, the teaching hospitals would cease to exist. It is only S.I.F.T. (service increment for teaching) which saved them. Within the last 20 years, more money has been spent on medical care and medical research than in all the years before. Yet in terms of increase in the duration of life or its quality we have almost nothing to show for it.

General surgery has suffered more than almost any other specialty from financial cutbacks and trimmings. In fact the setting up of special units whose activities could perfectly well have been carried out by general surgeons is a well known device for getting a special allocation of funds. I shall mention later how this process is a self-destructive one but meanwhile I am fighting hard at Guy's to prevent my office being taken over by an occupational therapist.

The Knowledge Explosion

I want to turn now to the effects of the explosion of biomedical knowledge on the every day clinical practice of the general surgeon. I have already said that George Doherty was able to keep abreast of developments in his field without undue difficulty. The situation facing the surgeon today is entirely different. We are suffering from the effects of the so called "technologic imperative" when every innovation is treated as being essential to the management of patients long before its value has been assessed?

As provocative examples let me take firstly transplantation; for years constrained by the notion (right in theory of course), that HLA antigen matching could be achieved sufficiently between cadaver donor and recipients to improve the results significantly. It is still difficult to prove after 30 years that there is a significant correlation. Meanwhile a whole industry of tissue typing laboratories, computerised kidney matching schemes, preservation machines and elaborate transplantation methods have been set up. Suffice it to say that many transplanters have ceased to use tissue typing except as a research tool.

Secondly let me turn to breast cancer screening. The common sense of finding disease early and treating it before it has done too much harm appeals to both doctor and patient—the analogy of course is keeping your motor car on the road by having it regularly serviced. But what sometimes appears to be common sense is not always true and the assumption underlying the commonsense of screening is that it does make a difference to treat disease earlier than later. Many studies have shown of course that the "pick-up" rate is 3-4/1000 women examined and the British Breast Group has recently reported the continuation of its evaluation in this country. One member dissented from the report.[2]

His reasoning and the reasoning of some others who doubt its value goes something like this. First there is no evidence of the value of screening affecting the mortality of these patients in this country. Of 18 breast cancers discovered in approximately 4,000 women in Edinburgh by screening, 12 were node negative and six node positive i.e. one third. With conventional presentation nine patients have lymph node metastases and nine are lymph node free. To assess the value of breast screening in this context we need to compare the additional number of lymph node negative cases discovered by screening, since the lymph node positive patients will have approximately the same course in each group. It can be calculated that for every six cancers discovered by screening only one additional lymph node negative case is picked up, a rate of 0.7/1000. Since it is well established that each cancer detected costs £6,000 the cost of the additional life saved is £36,000. This is a figure which according to an analysis recently published by my Registrar Mr. Michael Thick, would finance the cost of 18 open heart operations.[7]

Of course I recognise the enormous value of research programmes such as the ones I have illustrated and their high intellectual content. Breakthroughs come about only if research is broad based, but I feel that the intrusion of these methods into every day clinical practice should be carefully monitored. They should not be brought into widespread clinical use until their value is proven.

Specialties and Subspecialties

And now to a matter which I think is one of the major areas in which surgery has become diminished far too excessively—that of the hiving off of so called specialties and subspecialties—in fact as Michael Joyce, one of my colleagues said to me recently "There will soon be surgeons for the left kidney and surgeons for the right", put in more general terms, "If you think this patient has arachnodactyly and I think he has a dislocated lens we may diagnose Marfan's Disease". Of course many specialties have developed because particular skills are required. These may be so highly technological that the doctor must spend a great deal of time in acquiring excellence in performance. These then are service specialists carrying out tests at the request of the clinician, though of course their expertise in diagnosis often may appear to make the clinician redundant. At the other end of the scale are specialists who deal with different sections of the population, e.g. paediatrics and geriatrics. What is apparent to me is that there is an unnecessary degree of specialisation in surgery and I shall illustrate it by referring to urology and its relation to general surgery. On the 3rd September, 1977 there were 946 general surgeons and 127 urologists in this country. The British Association of Urological Surgeons has a membership of approximately 600 from which it follows that apart from the 127 full time urologists the majority of urology is carried out by the remaining 473 general surgeons. Now why did urology become a specialty? The operations are not vastly different from those of general surgery and on the whole are rather limited in number. The reason was the introduction of a technique which at that time seemed so formidable in its consequences that it was necessary to hive off those who elected to do so as full time urologists—the technique was of course endoscopic urology and in particular transurethral resection of the prostate. Now subsequent events have shown that urologists are in fact by no means able to cover all the

aspects of urological disease, witness the transplanters, the minority of whom are urologists, and the vascular surgeons who work on renal ischaemia. Both the latter groups almost take the surgical side of urology in their stride and of course another major factor has arisen since the creation of urology as a specialty, the fact that quite a large part of urological disease is investigated, diagnosed and even the decision concerning the operation, made by the nephrologist. The main point is that although historically there appeared to be fair reason to make urology a specialty subsequent events proved that it did not gather great impetus and events supervened which made it less of a "whole speciality"! Indeed I suspect that if urology had remained as part of general surgery and a judgement were to be taken at this time of the need for separating it off as a specialty, the answer would be to teach the general surgeons how to practice endoscopic urology and your problem is solved.

I mentioned earlier the self destructive aspect of super-specialisation so far as teaching hospitals are concerned. At present they base their *raison d'être* to some extent on training superspecialists, but what happens? As soon as these people are trained they go out into the country and set up satellite units in exactly the same way as they have been taught in the big hospitals and the supply of referrals to the latter dries up! This has resulted in situations where hospitals like the John Hopkins which originally received 80 per cent of its referrals from outside its district now has a 20 per cent referral rate and its subspecialty departments are now large revenue losers.

I believe that similar considerations apply to many of the specialties which have been separated off from general surgery. Surgery as a craft comes readily to those who have the aptitude. Amputating a leg is as little different from lung resection to a general surgeon who has had the necessary training. There is nothing very special craftwise about Vascular surgery or about urology which makes it impossible to practise both. Clearly in view of the long term effects of over-specialisation and in particular the changing needs of the population, a much more flexible and responsive system of surgical care is needed than is the case at present.

A new approach

I now wish to put forward some suggestions for a constructive approach to their solution.

(1) Clearly the morale of the profession as a whole needs urgent restoration. This can be achieved only if medicine is removed from the field of politics. The most sensible current suggestion seems to be that it should be under the overall guidance of a corporation such as that which runs the radio and television networks.

(2) Clearly the cost of medical care needs urgent control. Vast sums of public money are spent on the Health Service, of that there is no doubt. Unfortunately a very large proportion of that money is misspent. Most of us in our day to day clinical lives are struggling to get services or instruments costing a few thousand pounds which we find a hard enough battle but when the administration starts spending money

they think in terms of millions or hundreds of thousands of pounds. We as doctors have got to be concerned with how the money is spent in our individual districts and hospitals and where the very large sums of money that are handed out to the regions are dispersed. The time has arrived when the surgeon has got to be prepared to take an interest in the events going on around him and not be concerned just solely with his own small world. Our profession has been guilty of surrendering many of its responsibilities to the administration. It is administration that will continue to expand at the expense of the medical services in this country. We owe it not only to ourselves but to the public we endeavour to serve to reassert ourselves so that the high standards of medical care of which this country can be justly proud can be maintained in the future.

I think that in the field of Hospital Medicine the most immediate need is the construction or conversion of an average district hospital to be devoted entirely to a study of cost effectiveness of Health Care and for the results to be used as a model for modification of the remainder of the health services. It is totally wasteful of effort to attempt to derive cost/effective data from the existing National Health Service because the necessary figures cannot be extracted. In general the Americans are decades ahead of this country in studies of cost/effectiveness because they have a much more heterogenous health care system for which to draw data, *Medicare* at one end of the scheme and closely costed private schemes at the other with mixtures like the Kaiser Health Foundation in the middle. In this country we have only the National Health Service which cannot provide data, and the private sector which is inaccessible.

For almost the past year the *New England Journal of Medicine* has been publishing weekly special articles on these subjects and very interesting reading they make. Two of particular interest are "The Academic Medical Centre, a stressed institution",[6] and "Consumer-Choice Health Plan".[3] The one which appealed to me greatly was a scheme put forward by Alan Enthoven from the Graduate School of business in Stanford—A health insurance proposal based on regulated competition in the private sector. It makes good reading and is in the *New England Journal of Medicine*, March 30th this year. The proposal suggested that the Government changes financial incentives by creating a system of competing health programmes in which physicians and consumers can benefit from using resources wisely. Freedom of choice for consumers and physicians is ensured and the profession retains its autonomy. The system has built in rewards for economy in the use of resources and of course monitoring the quality of health care delivered. Physicians would have to accept responsibility for managing the total health care costs of the enrolled population groups. Acceptance of such a role would enhance the social contribution and recognition of the profession.

To return to the idea of a hospital based on cost effectiveness and its effect on general surgery. I believe it would allow general surgery to emerge from its present weakness to a new strength. It would be necessary for the appointed Superintendent of the Hospital to have time to provide leadership of the kind which is needed so badly to determine policy, and to be endowed wih the necessary managerial qualities to have doctors in charge again. It would undoubtedly be cheaper because

in general terms the more departments, the bigger the budget. With a smaller number of departments, the horrendous administrative and communications problems could be grossly reduced—imagine the number of cogs reduced by half. Each clinician having agreed to operate a cost/effective programme would change the interface between technological innovations and their clinical use in such a way that only those techniques of proven value were used. Moreover he would economise in the use of these whilst still maintaining adequate management of his patient's problems. The assessment of all technological innovations would be carried out at academic centres staffed by research oriented personnel. Now a difficulty—would it be unfair or acceptable to ask existing specialists to disavow their special departments and amalgamate in larger departments of surgery covering fields which at present are regarded as separate. Of course it would be difficult for the present generation, but remember that in future the surgeons emerging would not be specialists but general surgeons with special interests and would not therefore feel "deprived" if there were to be no separate Department for them. Moreover both the risk of redundancy (remember there will be 40,000 unemployed doctors in the E.E.C. in the 1980's) would be considerably reduced if the specialty became largely unnecessary through the adoption of new techniques since he would still have the flexible part of his expertise—the general surgery—at hand. He could from this base more easily learn another specialist skill than if he had been confined to his original specialty.

The surgeon would certainly enjoy the wider scope of operating and exposure to different categories of patients. To some extent after the first ten to fifteen years a surgeon's life is comparable to that of the repetitive worker. Have you ever asked a urologist about check cystoscopy lists? A change in job routine has exactly the same effect as a change on the assembly line worker—greater productivity. His expertise would be transferred to his apprentice surgeons who would gain a much more solid background of general surgery than most specialists have, but would equally have ample opportunity to develop the skills of their chosen additional specialty! Their training programme might be rather longer but the rewards when completed would be much greater.

A major spin-off would be that the system carries the right "mix" for undergraduate teaching. Gone would be the days of the infinitely complex curriculum, the appointment to a firm which ends seemingly just as he or she begins to feel part of the team and is really entering a learning process.

And finally what an incredible deal for the patient once again to be treated as a whole person by his or her doctor instead of being fragmented among twenty technocrats—in fact we have almost arrived at the good old days of George Doherty!

References

1 Avery Jones, F. Getting the N.H.S. back on course. Brit. Med. J. 1978. 2. 5.

2 Baum, M. Screening for Breast Cancer. Brit. Med. J. 1978. 2. 31.

3 Enthoven, Alain C. Consumer. Choice Health Plan. New Eng. J. Med. 1978. 298. 650.

4 Radical Statistical Health Group (1977). R.A.W.P. D.H.S.S., London.

5 Resource Working Allocation Party. Sharing resources for health in England (1976). D.H.S.S. H.M.S.O., London.

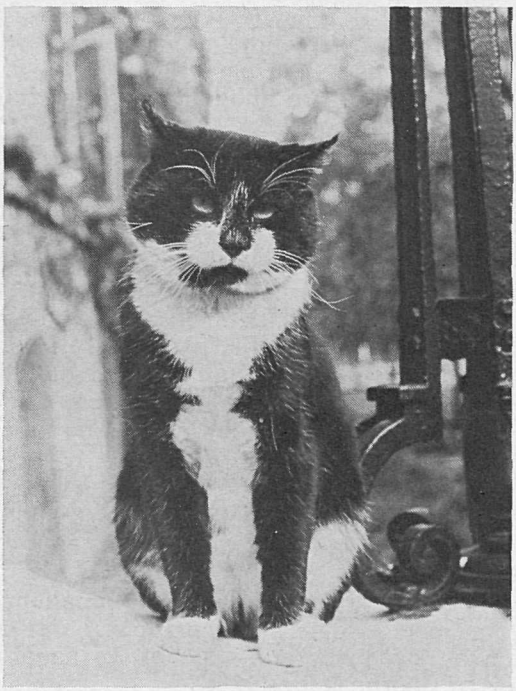
6 Rogers, D. E. and Blendon, R. J. The Academic Medical Center: A Stressed Institution. New Eng. J. Med. 1978. 298. 940.

7 Thick, M. G., Weaver, E. J. M. and Flavell, G. An attempt to measure the costs and benefits of cardiac valve surgery of The London Hospital in adults of working age. Health Trends. 1978. 10. 58.

Acknowledgement: Grateful thanks are due to the Council of the Medical Society of London for permission to reproduce the address.

Interview with Thomas Guy

Philip Razzell, a member of the Editorial Staff, interviewed the Hospital Cat outside the Wills Library late last month.



Thomas Guy alias "Butch". Hospital Cat and Gazette Personality of the Year, 1978.

Gazette: Firstly Butch may I offer my congratulations on your title "Gazette personality of the year".

Butch: Well thank *you*—I'm positively purring with delight! But please do sit down and make yourself at home, the drain cover here is acceptably warm. A saucer of milk perhaps, a loin or two of fresh rat?

Gazette: Thank you, no, I've just had some in the Spit. May I ask you *about your early life? As the Hospital Cat you have become a* national institution, yet your origins seem shrouded in mystery.

Butch: There's no mystery really. I was born in early April seven or eight springs ago, under the York Clinic. Lovely place! Such heavenly heating pipes! I never really knew my family. We'd been hospital cats for generations of course—a proud line descended from the original Borough Toms, but we were hapless victims of the Welfare State. The R.S.P.C.A. swooped that spring and found us all good homes—except for me. It was terrible, terrible. I still have nightmares about waking up in a soft armchair or lapping warm milk, or worse still squatting over a box of sawdust, Mieow! So *bourgeois!*

Gazette: What happened after the R.S.P.C.A. left?

Butch: Though still a kitten I knew my cat-call. The mantle of Hospital Cat had fallen to me and it was a job I had to see through. *Dare quam accipere* and all that. I set up my base of operations outside the Medical School and that's where I have been ever since. I don't know what would happen to the place without my eye on it. It's like the Ravens in the Tower, you see.

Gazette: And what as Hospital Cat is your view of Guy's today?

Butch: Well bend a bit lower and you'll see it. It's only 6 inches up on the worm's eye view but it's a lot more interesting.

Gazette: You mean . . . ?

Butch: I mean no more than I've said. From your elevation you look down on heads. I look up with respect; sometimes tinged with wonder, admiration and occasionally shocked surprise. You should see things from my angle for a few hours occasionally.

Gazette: Talking of your pastimes, Butch, there have been various estimates of the number of kittens you have sired . . .

Butch: Yes indeed, I've been a gay dog in my time, if you'll pardon the expression, but we have a saying in the Borough that 9 lives calls for 9 wives. My days aren't over yet, though I'm a little troubled by rheumatics in my back legs and I'm sure this warm drain cover has an adverse effect on my fertility. True, I don't conform to Kipling's image of "the cat that walked by himself", but I've done my duty as I've seen it, and if every sector of the N.H.S. was as productive Guy's wouldn't be in the mess it is today.

Gazette: Do you plan to spend a family Christmas, Butch?

Butch: I think not. Christmas will be business as usual.

Gazette: Some cat-lovers have been anxious about your appearance, can you reassure them?

Butch: Well that is something that has been bothering me too. What with Mr. Wheeler and Miss Farmer plying me with food, and sweeping the frost off my fur I must admit that sometimes I look almost respectable. But you see it is part of my job to look after these people and if they feel that they are being useful that makes me happy. What they'd do without me I don't know.

Gazette: In your years in the park you must have frequently mingled with the famous.

Butch: Indeed yes, I was privileged to know both Waldi and Maximilian, and of course Minnie Wills still runs the library.

Gazette: I'm sorry could you explain?

Butch: Explain? Waldi and Max were the dachshunds who looked after Mr. Wheeler—my you *are* a young man! And you must know Minnie, the cat that always wants to know what you're reading? My paws, I could have made a woman of her once, before the vet got to her that is. Such a pity she's put on weight, but they say it often happens.

Gazette: I suppose you know Mr. Wheeler quite well?

Butch: St. Francis? Yes, I keep an eye on him. He thinks I don't know about the seed he buys for the pigeons, the poor man. Honestly, he would befriend a fallen starling in the park. Sometimes I despair.

Gazette: Do you have any contact with cats from other hospitals?

Butch: There's only *one* hospital in London and you'll do well to remember it. I sometimes visit Kings Cottage and that first aid post near Waterloo, for social reasons. Have you seen the cats there? You must have noticed the family resemblance? Ah, there's many a good tune played on an old organ!

Gazette: Do you see yourself becoming a cult figure?

Butch: A cult figure? Dear me no! I can just imagine it—cameras clicking all day long, microphones in my whiskers, "I love Butch" sweat shirts in the Union shop. No my dear boy, I like nothing better than to sit here quietly and keep the place running. Now, are you sure I couldn't interest you in a leg of rat?

Guy's Hospital Gazette

We should like to remind our readers that all copy for inclusion in the "Gazette" must be received 12 days before publication. Copy dates for the next 2 months are: 15th January and 15th February, 1979.

Copy may be sent to us at 16, St. Thomas Street, SE1 9RT.

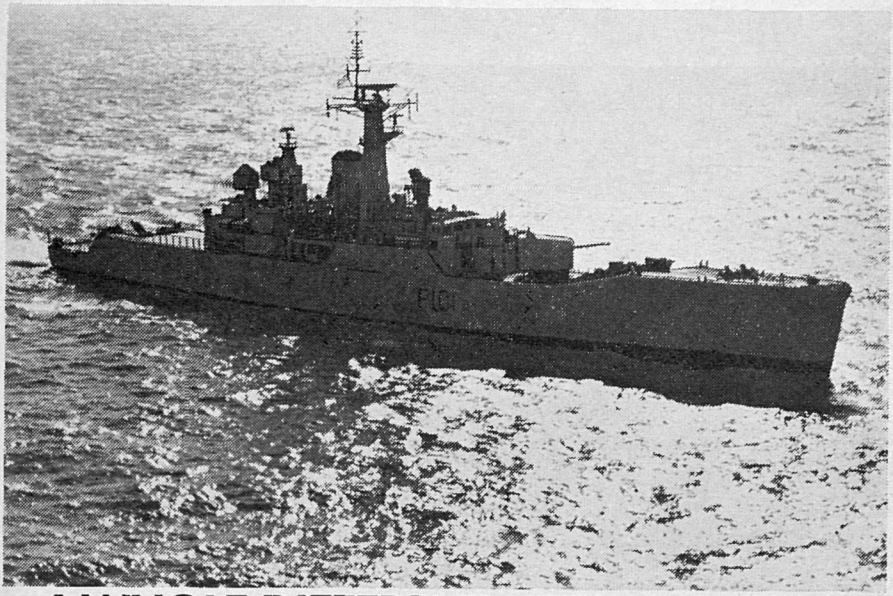
Birth, Marriage, Death and Change of Address notices are inserted without charge to subscribers.

When subscribers notify the "Gazette" of Change of Address, would they please indicate whether or not this should be published.

Personal notices are charged at 10p per word (pre-paid, minimum £2.00).

Non-subscribers are charged £2.00 (pre-paid) for all notices other than Death.

£2,636 A YEAR WHILE YOU'RE STUDYING.



A WHOLE DIFFERENT LIFESTYLE ONCE YOU QUALIFY.

This year a select few men and women will be awarded a Royal Naval Dental Cadetship.

If you have a 2nd BDS (or equivalent), and you can pass our interview board, we will pay you £2,636 a year as a student.

On qualifying you'll start a 5-year Short Career Commission as a Dental Officer.

Two of those years could be spent at sea in a surgery with all the equipment and clinical freedom you would find ashore.

Or you could spend short periods being winched from ship to ship by helicopter – a sort of Flying Dentist! – carrying your complete dental surgery with you.

Most of your time you'll spend ashore – on a Naval training establishment for instance, or at a NATO base.

Either way, you'll also have a second title – Naval Officer. While you're at sea you'll be part of a team running every aspect of the ship.

And enjoying superb sports and social activities as well.

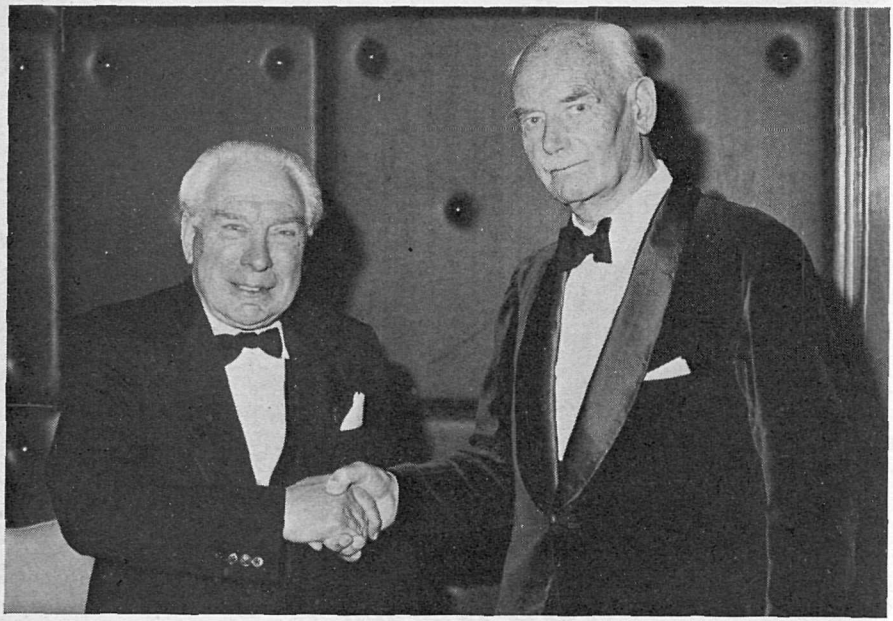
Pay? If you join immediately after you qualify, your salary will be £6,517. And at the end of your 5-year Commission you'll leave with a tax-free gratuity. Or you can apply for a Full Career Commission or a 16-year Medium Career Commission, both of which are pensionable.

If you'd like to know more, write giving details of your age and qualifications to: Surgeon Captain (D) F.R.B. Mathias RN, (26GS), First Avenue House, High Holborn, London WC1V 6HD.

ROYAL NAVY DENTAL CADETSHIP

Fifty years ago at Guy's

by Mr. R. C. CANN



The author and Mr. Kenneth Hooper at the recent Guy's Biennial Dinner in the Connaught Rooms. Mr. Hooper was this year's Chairman.

One of the privileges of age is to think backwards though the quality of memory may influence the result. Thus I protect myself from criticism or correction when complying with the Editor's request for a contribution to this issue of the *Gazette.* I propose to think back to an incident of the mid nineteen twenties when I was a House Officer.

It will be helpful if I set the stage, for Guy's was a very different place then. No new Guy's House, no Tower Block, no Wolfson House, in fact Great Maze Pond was a public highway, separating Southwark and Bermondsey, and one only crossed it or went underground to reach The Colleges or the *Ship and Shovel.* Entrance to Guy's was from St. Thomas' St.—past the statue of our founder and into the Colonnade. Here, by the porters Front Lodge, we would wait in groups for the arrival of our Firms' chief for his teaching round or operating session. From Maze Pond there was a side entrance through the War Memorial Arch (may it soon be restored and returned) and at the south end were two doorways—one into the Out-patient Hall and the other to the Front Surgery, or as one would now call it, the Casualty Department. The anomalous title of Front persisted from the time when casualties were

seen in the front of Guy's House at what is now about the centre of the students' cafeteria in the East Wing. Guy's House contained the Surgical Wards and the main operating theatres. In Hunt's House were the Medical Wards, also, one ward for Gynaecology with a small addition for midwifery complications, a ward of private cubicles the precursor of

The baronial splendour of the students' dining room in the College, a far cry from today's facilities.

Nuffield House and on the ground floor two inter-communicating wards, Ruth and Barnabas for the Ophthalmic and Ear, Nose and Throat patients. Alongside these wards, with windows to the Park, were a theatre and a dark room for Eyes and a theatre for Ear Nose and Throat. The principal entrance to this area was from the main hall of Hunt's House but there was in addition a small side door from the Park into Ruth Ward just adjacent to the present door to the Catering Department.

We have now reached the location for my story. But first let me say something of myself. I was in the middle of my first House Appointment being the senior, by three months, of the two Ophthalmic House Surgeons. Ophthalmic was only a partial description of our activities for we were each responsible for half of the Eye Department beds, half of the E.N.T. Department and, for the second half of the appointment the senior was in charge of the Orthopaedic beds as well. In addition we were expected to help in Out-Patients, to arrange admissions and operation lists and frequently to act as anaesthetists for each other, particularly for emergencies. Finally, we were, in turn for a week, the take-in House Officers for our Departments.

To obtain a House Officer position it was imperative to become one of six resident Clinical Assistants who were chosen, each three months, from among the newly or recently qualified students. Like the ten little niggers, at the end of this appointment five of the "Clinicals" became assistant House Surgeons and one was dropped. After another three months a lucky four became Out-patient Officers—serving on alternate days as Casualty Officers or Assistants to Medical Out-patients. The four O.P.O.'s were then elevated to full House Officer appointment, each for six months, becoming two House Physicians and two House Surgeons. This time there was no dropping of a nigger! However, the two who had been dropped had a second chance, of other full House Officer appointments each for six months such as Ophthalmic or Genito-Urinary House Surgeons and occassionally Resident Obstetrician. You will deduce that I was the first nigger to be dropped from my group of Clinicals which included a future Guy's physician, Professor of Surgery, Skin Consultant at Bristol and principal medical officer in the Prison Service. I had no regrets, but at that time I did not know how fortunate I was to be: however that is another story!

The Memorial Arch and College in their declining years. New Guy's House can be seen on the right.

There were 14 full House Officers and it was only these who benefited by free board and lodging in the College. No salaries were paid except to an Out-patient Officer if he chose to live out for his three months appointment—when he received £3 per week.

(Continued on page 492)

FRIGIDITY

IN WOMEN

due to
Undersized Clitoris
can be treated by

NEO-HOMBREOL OINTMENT

INFORMATION ON REQUEST TO:

MEDICAL SERVICE DEPARTMENT

ORGANON LABORATORIES LIMITED

77 NEWMAN STREET, LONDON, W.1

Telephone: MUSeum 2857 (3 lines) *Telegrams: Menformon, Rath, London.*

East Africa: Howse & McGeorge Ltd., Nairobi, etc.
South Africa: Heynes Mathew Ltd., P.O. Box 242, Cape Town
Australia: F. H. Faulding & Co., Ltd.
New Zealand: Dominion Dental Supplies Ltd.
Malta: J. Meli, Valetta
India: Morison, Son & Jones (India) Ltd., P.O. Box 258, Bombay
Ceylon: Morison, Son & Jones (Ceylon) Ltd., P.O. Box 430, Colombo
Straits Settlements: Grafton Laboratories Ltd., Singapore

TRUSS FITTERS

sent anywhere at *short notice*

Fully qualified and experienced men and women fitters are immediately sent out to urgent or special cases at reasonable fees on receipt of your letter, telephone call or wire. We are already privileged to serve many doctors in this way. Please send for details. In addition, a fitting staff is always on duty at the addresses below

Telephones:
London—Holborn 4813 Manchester—Central 5031
Liverpool—Royal 6548

Brooks Appliance Co., Ltd.

(301S) 80, Chancery Lane, London, W.C. 2.

(301S) Hilton Chambers, Hilton St. Stevenson Square, Manchester, 1.

(301S) 66, Rodney St., Liverpool, 1

All residents were, of course, fully registered. The first act after passing a qualifying exam was to go to Hallam St., pay the necessary fee and have one's name added to the Medical Register and thus to be licensed to "prescribe drugs" and to sign death certificates! I had had the benefit of being able to leave Guy's for six months, immediately after qualification, and to enjoy the experience of a number of varied locum appointments, mostly in General Practice. An incidental but vital benefit was being able to save £100 and thus finance my period of "Clinical". It must be realised that at the time of the distressing and unexplained experience, which I shall describe shortly, the facilities for communication at Guy's were very different from the present day. No one had thought of a bleep or other call system. An automatic telephone installation permitted an internal link between wards and departments and with the porter on duty in the Front Lodge and in the residential College. The only links with the outer world were by a Post Office telephone in the Front Lodge by another in the College and a third in the Front Surgery. I do not remember any other "outside phone". Hence all patient enquiries were made to the Front Lodge; followed by the Porter there using the internal phone to the ward and finally passing the answer by the outside phone—time consuming, frustrating often to caller and fraught with much opportunity for error!

One Saturday evening, before dinner, I was called to the Front Surgery —a frequent occurrence during one's week of "take-in" duty. I was asked to see and deal with a youth of about 18 years who I considered was suffering from an acute mastoiditis and needed admitting for an operation that evening. This lad was accompanied by his mother and the pair had spent most of the day visiting and waiting in several hospitals, unable to secure the needful admission. They lived in the East End of London and I suspect had tramped from one casualty department to another until they reached Guy's. When I arrived in the Front Surgery they were sitting huddled together on a bench, the mother worn out, the boy in pain, pyrexial and toxic and curiously loth to leave her side for my examination of him. I explained the need for an operation and said I hoped it would be done later that evening, as I knew we had another similar emergency already in and I had arranged for our Registrar to come to operate after dinner. I urged the mother to return home to get some food and rest and suggested she should telephone the Hospital for news at about 11.30 p.m.

Acute mastoid surgery was a frequent emergency in those pre-antibiotic days. The fear was the possible complication of meningitis just as peritonitis was the spectre behind the acutely inflamed appendix. My two patients for this Saturday evening were in Barnabas Ward and the operating was done conveniently in the theatre adjoining the ward. By this time I had been allowed to do a number of such operations, always under supervision, though supervision was a variable quantity! I cannot remember who was the operator for the first case but I certainly remember that I did the second, the 18 year old from the East End. My supervisor, our Registrar, sat and read in the corner of the theatre, my House Officer colleague gave the anaesthetic—mainly ether on an open mask—and the Medical Night Sister was in charge of the theatre. There was a head nurse and a probationer in the adjacent ward. A quiet peaceful evening! and nothing untoward happened during the whole session. The Registrar went home, the bandages were put on, the patient

lifted to a trolley and wheeled direct across the ward to his bed where having helped the sister to make the boy comfortable I left them.

With a worrying problem in another ward I had decided to telephone my orthopaedic chief and so strolled across the Park to the Front Lodge. As I finished my conversation the internal phone rang with a message would I go urgently to Barnabas. So back I ran and into the ward by the side door direct from the Park to find sister and nurse trying to revive my last patient, but he was lifeless. The story was that he had begun to be restless and then suddenly stopped breathing and was, at the same time, found to be pulseless. There was no obstruction to artificial respiration. Nothing would revive him and his dying was a mystery. It was now nearly midnight and I realised that I had had no telephone enquiry about him. I could not phone his mother, they were too poor for such a convenience. I was wondering what I could possibly say when the ward phone rang. I answered it—the familiar voice and routine message. "Father of —— on the phone sir, enquiring after his son's operation."

"Tell him to hold on. I'm coming over to speak to him myself."

I ran back to the Front Lodge.

"It's the House Surgeon speaking—could you possibly come up to Guy's?"

"Yes sir—is the boy dead?"

"I'm sorry to say he is."

"All right—I'll be there as soon as I can."

And that is all that passed between us during that phone call.

I spent an unhappy two hours, walking about the Park and the Colonnade waiting for the father. I could think of no explanation to offer. The boy had not died because of his illness; there was nothing in the operative session or in the period of early anaesthetic recovery to account for it. He had the Night Sister by his side since I left the ward, as one of the two nurses had gone to her meal. What should I say?

The father arrived and to my relief accepted my account of events without any question or criticism and even apologised for being so much later in telephoning than I had earlier suggested. I then said why had he simply replied "Is the boy dead?" when I asked him to come and see me.

"Well sir—I was just getting ready to go out and phone, about 11.30, when my wife cried out saying 'He's dead'. She became so upset and hysterical that I had to call in a neighbour and then find a doctor, before I could telephone the hospital. That's why I was late."

On the Monday following, a post mortem examination revealed no cause of death. The coroner was informed and relieved me of the question of an inquest. I signed the death certificate as post-operative shock following acute mastoiditis.

But why did he die? I had been impressed when first seeing mother and son, how close to each other they seemed. I was very aware of the boy's fear of leaving her, of coming into hospital and of having an anaesthetic. I have often thought that in a person gradually losing consciousness and later gradually regaining it that their thoughts and fears returned as a continuing state and without any awareness of the intervening gap. My patient had died as he was regaining consciousness. Did he die of fright?

But if we theorise to our satisfaction in this way what do we say concerning his mother's awareness of the **exact** moment of his dying!

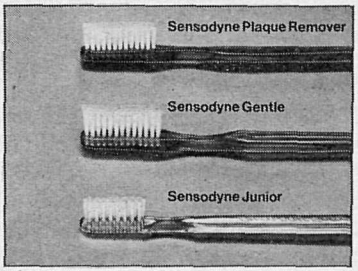
Brush-upmanship

As any toothbrush buff will tell you, thoroughly-researched design features and high quality manufacture put the Sensodyne toothbrush range one-up on the competition. With straight handles, rounded contours, double-rounded nylon filaments and a range of brushes to meet the specific needs of patients, Sensodyne toothbrushes can hold their own in any company.

Sensodyne Plaque Remover
a general-purpose toothbrush for adults.

Sensodyne Gentle
for patients with dental hypersensitivity and for post-surgical use by periodontal patients.

Sensodyne Junior
shorter filament length, small head and easy-grip handle make this the brush of choice for children.



Sensodyne Toothbrushes
better designed to fight plaque and tooth decay

If you'd like more information or a sample, write to Stafford-Miller Ltd., Professional Relations Division, Hatfield, Herts.

Issues in General Practice. Contributions should be sent to The Editor, Guy's Gazette, 16 St. Thomas' Street, SE1 9RT.

Closeness to the Patient . . .

by Dr. S. E. OPENSHAW, Glastonbury, Somerset.

The best thing about general practice is this; you are on your own with the patient. When I work in a specialist clinic with nurses and receptionists I can't keep the nurses out of the consulting-room. They come bounding in with trays of vaginal speculae and bang them down on the trolley, announcing in menacing tones, "I thought you might need these". After that sort of interruption it needs all my personal magnetism to bring the patient back to the point of being brave enough to tell me she is knocking her children about.

Once a receptionist actually came in with a cup of tea at the moment when I was trying to remove an I.U.C.D. from a woman who was having a succession of fits after my quite skilful insertion. The way I deal with this problem is by locking the door.

In general practice, of course, there are nurses and receptionists, but in our practice they never come into the consulting room except at the invitation of the doctor.

Besides being alone with the patient, I like them to be near me, within reach, so that I can examine them; sometimes, if I want their buttons undone, I absentmindedly undo them myself. I do work more effectively at close range. I also like to be near the patient in status. I work together with them. I know more about diseases, and they know more about themselves. I don't at all mind looking up information while they are in the room; in fact, in dermatology (about which I am not very knowledgeable), we look at the Skin Atlas together, and while we may not arrive at a precise diagnosis, the patients always go away feeling remarkably comely compared with the people in the photographs.

In the final analysis, I am technically superior to the patients in medical matters, and I don't need a white coat or a nurse or a team of junior doctors following me round to prove it. And any barrier between me and the patient would interfere with the particular job of a general practitioner, which is to get across to the patient things he needs to know about how to live, work and be content, whatever his disability may be. You can't help a patient in matters of that sort unless you know a good deal about him, and you can't know about him unless he chooses to tell you, which is where we come back to the business of getting on to the same level as the patient. After all, he will know you are a doctor; you don't need to emphasise the point to him. You don't have to dress up to impress him. I usually try to comb my hair before surgery, but I don't always remember.

All you really need is something simple, like a stethoscope. I used to have a marvellous stethoscope; it was about 4 ft. long and had black rubber tubes. My pernicketty son Peter thought it was acoustically unsound, but I don't think he allowed for the echo. This was the only stethoscope I have ever had with which you could examine the back of the chest while looking the patient straight in the eye. And anyone

could identify the wearer as a doctor at 40 paces in a dim light. In the end it developed a nasty perforation in the tubing, and I found, as I had feared, that it was irreplaceable. So I had to get one of these new light-weight articles, pleasant for the aging cervical vertabrae to support, and it doesn't get between my knees when I am trotting round the Health Centre; really surgeons and psychiatrists could save money and only buy the earpieces, which would fit neatly in to the breast pocket and do all they needed as a status symbol.

To come back to closeness to the patient—I actually sit a lot of patients on my knee to examine them, starting at about 6 months old and going right through to large prep-school boys. It is remarkable how children allow you to examine them when they are sitting on your knee. I always do this to examine the eardrums, and usually the chest. You can learn a lot about a child when he is sitting on your knee; how ill he feels, what his balance and muscle tone are like, and so on. I have only once had the sad experience of being piddled on, and then it wasn't very much.

How many of you who work in hospital have noticed a difference in your approach to patients in a side ward? In the main ward, you may ask courteously if you may examine a patient, but you would be very surprised if they refused. In a side ward you feel you are an intruder, on the patient's own territory. Actually whenever you examine a patient you are an intruder, but it is convenient to forget this. It is much more difficult in hospital to achieve close understanding of the patient, because, in hospital, patients are at such a disadvantage. I remember an elderly gentleman being admitted to a large general surgical ward. "This place" he pronounced, glaring round him, "is like a mixture of a lunatic asylum and an emigrant ship." It was a sadly accurate remark. Not many people can retain their dignity in bed in the equivalent of a co-op store.

At this point I have to invalidate all I have said by admitting I am a woman. It is a well-known fact that the opinions of women are light-weight, due to the flood, or at my age, the ebb, of hormones through our regrettably small brains. When my male colleagues throw letters at the secretaries, instruments at the nurses, and muffled curses at other doctors for stealing their bottles of clinistix and headed note-paper, they are behaving reasonably as a result of logical thought; all that banging about has nothing to do with the bombardment of their admirably large brains by testosterone.

Women, on the other hand, are creatures of whim and fancy. I wouldn't have admitted to being one, but I want to mention a danger of this togetherness.

Some years ago I was called to see a cattle-dealer with acute retention; he was rather drunk and intended to complete that process as soon as he had been relieved of his predicament. West-country cattle-dealers are crooked, low sort of men and he was a mongrelly, wall-eyed fellow. If he had been a dog, you would confidentally have taken him ratting. I put him on the couch, undid a few buttons, and determined the size of his bladder. I was just getting down to the important bit when he sat up and glared at me with his one good eye. I had forgotten I was wearing a nice jersey and skirt, and not even a stethoscope to prove my credentials. "I'll take that lady's name and address!" he cried. It must have been the only time in his life that he felt genuine, justified righteous indignation.

A History of Guy's Hospital Rugby Football Club – 2

by Mr. T. L. T. LEWIS

1880's

In 1886 Alfred Fripp (later Sir Alfred, on the Guy's staff) "a powerful, hard-working forward weighing 13 stone and as hard as nails" was secretary and arranged a card of fixtures which had never been achieved by any hospital before. He will be remembered as the instigator of "The Ancient Order of Froth-Blowers". In the following year, 1887, when he was captain, the three-quarter line was a wholly international one with W. G. Mitchell (England), H. L. Evans (Scotland), F. G. Swayne (the South) and H. M. Jordan (Wales). Also in the side were "Honest" John Fawcett and J. H. ("Rosie") Bryant, both of whom were appointed later to the hospital consultant staff. For the first time in hospital football a provincial tour was arranged. They were narrowly beaten by Bradford and Wakefield Trinity, the latter being the holders of the Yorkshire Cup, but "did not cut too bad a figure". Against the odds they were beaten in the Cup competition by a dropped goal to a try by St. Thomas's "who kept the ball tight in the scrums and tackled relentlessly". It seems that Cup matches do not change in the course of time. Through the efforts of John Fawcett the Surrey County R.F.C. was resuscitated.

The captain for the next two seasons, 1888–9 and 1889–90, was that remarkable athlete, Alfred Allport, from whose article in the bicentenary number of the *Gazette*, January 6th, 1925, much of this early information was obtained. Allport played rugby for England five times, rowed for Thames in the Grand Challenge Cup at Henley and was near to winning the Amateur Heavyweight Boxing Championship. He was a great personality and renowned for his comic songs. Allport was greatly assisted by W. G. (Willie) Mitchell, also an all-rounder, a most unusual athlete excelling in soccer, cricket, hurdling, golf, billiards, tennis, racquets and putting the weight, to say nothing of rugby, at which sport he represented England seven times, playing full-back. He was quite unorthodox, tackling by the hand, shoulders, arm or jersey and often he fly-kicked the ball into touch thirty or forty yards away instead of picking it up (this presumably due to his prowess at soccer). He frequently turned up for an International match without any kit, even boots. Playing three-quarter on one occasion, he mistook his own goal for his opponents' nearly scoring a try behind his own line, recognised the Guy's full-back in a friendly manner, turned round and made a fine run in the opposite direction. A few moments later he dropped a goal from half-way, meaning, he said, to kick for touch. Once, in an International match against Scotland, he let a forward through, doing one of his usual high tackles, followed the man over the goal-line, caught him up without being seen and neatly took the ball out of his hands as he was about to ground it! Unpredictable to the end, he went to the Yukon in the gold rush and died

of phthisis there in 1905. 1890, incidentally, was the opening year of the Residential College and the Pavy Gymnasium, both to play a big part in the lives of generations of Guy's men.

J. J. Biggs, the eldest of four famous Welsh brothers, was another valuable acquisition who could play anywhere on the field. He was "a tall, bony man with a hard pair of knees, unkempt hair and a big moustache". His Celtic excitability led to many a dispute, the evidence for which was "his great moustache all covered with blood".

1890's

The Guy's team was not particularly successful in the early 1890's. Notable players included W. I. (Bertie) Hancock, "a tall, loose-limbed three-quarter with a walloping gait, an awkward swerve and the true instincts of a centre to draw his opponent towards him and then to free his wing"; K. B. Alexander, "the pocket epitome of pluck and reliability"; H. W. Dudgeon, a fast, strong and skilful wing-forward who played for England seven times; F. O. Stoker, a forward who had already played five times for Ireland; T. L. Jackson, a Cambridge Blue, and F. C. Wetherell, a clever half-back who represented the hospital for many years. Bertie Hancock was captain of Guy's tennis six, played cricket for his county and was regarded as one of the best three-quarters playing rugby. But for a knee injury he would undoubtedly have been famous. Bent on a distinguished career in ophthalmology, he died at 36 from pulmonary embolism following a straightforward appendicectomy.

Two events from this period are worth recording. Guy's had played for many years on the common at Blackheath. In 1872 a ground was acquired at Nunhead but was too muddy and wet and a return was made to Blackheath. In 1888 the club obtained a ground for playing rugby and soccer at Raynes Park. This was not entirely satisfactory because the changing-room was a cowshed with generous cracks through which the wind whistled, there was no water and the distance from the hospital was a great inconvenience. In 1891 the Clubs' Union was formed and the present ground purchased at Honor Oak Park for the purpose of playing rugby, soccer, cricket, athletics and tennis. The ground was officially opened in 1893 by the Hospital President, Mr. Durham, in the presence of the whole consultant staff, many old Guy's men and students, and the Band of the Scots' Guards. The other event concerns the Cup. On the 15th March, 1898, St. Thomas's had won the Cup nine times in succession and were in the final again against Guy's. Their captain received a telegram that morning bearing a Borough stamp and containing the ominous warning, "Beware the Ides of March". Guy's won and according to *The Sportsman*, "there were scenes of indescribable enthusiasm as F. C. Wetherell, the captain, was carried shoulder high, holding aloft, amid tremendous cheering, the much-coveted silver trophy". R. C. Mullins (Mull) from South Africa, was a magnificent leader of the scrum on that occasion and captained the side for two seasons, 1898–1900. F. W. Sime, the Scottish sprint champion, was on the wing, and also playing were F. L. Rae, F. D. S. Jackson, T. P. Thomas, H. A. Cutler and P. T. Manson. Manson, the young son of Dr. Patrick Manson, died tragically from a gun accident while investigating tropical diseases on Christmas Island in 1902. From this time on, Guy's took a definite place amongst London's first-class clubs. The standard of the players was very

high and a substantial proportion played in representative matches. Amongst many distinguished players one must single out one of the greatest Guy's can claim, Teddy Morgan, who joined Guy's in 1899 and became one of the most brilliant of Welsh wing-quarters. He played for Guy's until 1904.

1900's and Teddy Morgan

Teddy Morgan was "small, compact, agile as a monkey, had a wonderful kick and would tackle anything". He was extraordinarily quick off the mark and was very fast on the football field, with a beautiful swerve either way. He played for Wales sixteen times between 1902 and 1908, but will always be remembered for the historical try he scored for Wales at Cardiff on December 16th, 1905, to break the All-Blacks' winning record. This try was hotly disputed by the New Zealanders and even now it is possible to start an argument in their country by mention-

Season 1902–03

E. H. B. Milsom. E. L. Ward. S. M. Saunders. L. J. J. Orpen.
A. M. Tolhurst. B. Glendining. W. G. Pinching. F. Alcock.
R. G. Anderson. E. M. Harrison (Hon Sec.). A. B. O'Brien (Capt.).
P. F. McEvedy. E. Morgan, M. G. Louisson, F. J. Cutler.

ing the occurrence. In his first Cup match against St. Mary's the referee objected "to the vigour infused into the tackling", stopped the game and cautioned him for rough play. This much amused the players for he was by far the smallest man on the field. With Morgan in the Guy's three-quarter line were A. B. O'Brien, his centre, who according to Morgan was "wonderfully clever in all he did, a beautiful kick, drop or place, and blessed with the safest of hands"; P. F. McEvedy, a hard, low, deadly tackler and F. Alcock ("the Baron") a wing three-quarter weighing over 14 stone and only 5 feet 9 inches, "his path to the line was strewn with the bodies of would-be tacklers who were probably asking themselves

if an avalanche had passed over them". L. J. J. Orpen, an Oxford Blue, was also a speedy wing who scored many times for Guy's. E. M. Harrison was a first-class full-back. O'Brien and McEvedy were both New Zealanders. The forwards included R. C. Mullins, D. H. Trail, T. P. Thomas, H. A. Cutler, R. C. Lawry, S. McKay Saunders, A. H. E. Wall and A. Ralph Thomson, who later became genito-urinary surgeon to the hospital. In 1904 Morgan, O'Brien, Trail, McEvedy and S. Mackay Saunders toured Australia and New Zealand with D. R. Bedell-Sivright's team, and Morgan, O'Brien, McEvedy and McKay Saunders played for Kent when they became County Champions. The fixture card contained many teams no longer in existence, Lennox, Croydon, Kensington, East Sheen and Marlborough Nomads. In 1902 Guy's beat both Oxford and Cambridge. Many critics drew attention to the fact that it was so much easier to gain International honours from the 'Varsity sides or from one of the more "fashionable" clubs than it was from a hospital. And here was Guy's trouncing Oxford by 24 points to 8 on their own ground in the absence of their regular half-backs, O. V. Payne and M. G. Louisson, through injury! Of 19 matches played in the season, they won 14 for 187 points against 105.

Sixpenny "Gate" pays for Stand

In 1903 a sixpenny "gate" was introduced for rugby games at Honor Oak Park and such was the success of this venture that, with the help of the *Gazette* and the Clubs' Union, it was decided to build a stand. Work started the same year.

Following the Teddy Morgan era when the three-quarters were pre-eminent, the Guy's pack took over and became extremely formidable. In 1905–6 it contained three future England Internationals, H. A. Archer, A. J. Alcock (future president of Gloucester R.F.C.) and G. R. Hind. In the same class were H. R. Mullins (brother of R. C.), McKay Saunders and W. G. Pinching, a worthy son of "Nipper" Pinching of the seventies. H. Lee, Cambridge Blue and future English International, was full-back. On one occasion E. G. Slesinger, a regular member of the 2nd XV, subsequently Senior Surgeon to the Hospital, played at half-back for the first team. The side went to Paris and beat the Racing Club de Paris. This year scoring became firmly established and, with the exception of 4 points for a dropped goal, was as we know it now. In the following year, when every forward in the pack was a county player, they went to Bordeaux and defeated the Stade Bordelais team. The tour seems to have been memorable on account of the team's liking for the local wine and also because of an interview with the gendarmes over a large plate glass window which fell out of its frame and broke without anyone touching it. It was during this season, 1906–7, that Guy's, under the captaincy of the New Zealander S. McKay Saunders, took a leaf out of the 1905–06 All-Blacks' book and allotted fixed places in the scrum for the forwards. Although this was criticised as a tactic likely to cause delay it was soon followed by others, first of all in Wales and then universally. Once again Guy's were the pioneers of a development in rugby football that was to become accepted practice.

To be concluded next month.

S.M.E.C.

As Dr. Johnson rightly observed, *"whatever is proposed, it is much easier to find reasons for rejecting than embracing . . ."* This phenomenon is well known to everyone involved in monitoring the medical curriculum at Guy's and working for its improvement, not least the new members of the Student Medical Education Committee. However, the new S.M.E.C. is approaching the task with enthusiasm, albeit tempered with caution as its complexity becomes apparent!

The Clinical Years—more practice in "exam technique"?

With the recent fuss about M.B. Finals results attention has focused on ways to improve clinical teaching. The introduction of opportunities to practise exam techniques is proposed, perhaps in the form of short and long cases at the end of firms. S.M.E.C. would welcome special tutorials in the last two firms before finals, and would not object if these were shortened to allow a longer revision period. An increase in In Course Assessment can be expected in the future. S.M.E.C. supports the idea of moving one of the surgical firms to a busier district hospital. There are too few surgical beds (or too many students) at Guy's.

A Clinical apprenticeship?

The committee proposes an introductory period of one or two weeks for students beginning their clinical training, where they can work alongside senior clinical students. This might ease the transition from Medical School to Hospital which at present occupies much of the first firm. Of course this might mean a week or two less holiday after B.M.S.

Career Guidance

S.M.E.C. is at present considering an ambitious plan to organise a personal tutor system for the senior clinical years, to offer among other things career guidance. More information may be had from Wesley Scott-Smith, (see your *Gazette* next month).

More participation

From the suggestions above it might be said (unfairly I think) that S.M.E.C. is campaigning for "more exams and less holidays"—indeed if you do think this your S.M.E.C. representative would be pleased to hear from you. S.M.E.C.'s only authority in our corridors of power is the authority of directing the collective student voice. To do that it must have your active participation. The members of the present committee are published in *Hospital Information,* and minutes are on display in Boland House.

Paul O'Hare

Many of the proposals currently sponsored by S.M.E.C. have been inherited from the '77-'78 committee under the able Chairmanship of Paul O'Hare. The exceptional contribution that Paul has made to the improvement of our medical courses at Guy's over several years is gratefully acknowledged by the present committee. Indeed, the very existence of S.M.E.C. owes much to his efforts. We are very fortunate to be able to draw on his astute advice and fund of ideas in the coming year!

Philip Razzell, Chairman.

Quodlibet Society

Professor Bryan Ranft.
"Britain's Armed Forces. What are they for?"
21st November, 1978.

Prof. Ranft is currently at the Dept. of War Studies, King's College, and was formerly Professor of History and International Affairs, at the Royal Naval College, Greenwich. Prof. Ranft spoke only briefly of his vast military experience, with the main theme of his presentation being impact of nuclear weapons on conventional ideas of war and defence.

Few can be unaware of the influence that the nuclear age has had upon military strategy and diplomacy. The desire of the super-powers to maintain a nuclear arms race, is paralleled by the build up of sufficient and suitable defence systems by the smaller nations. This spiralling acceleration, an unimpeded proliferation, presents not only colossal economic demands upon the super-powers primarily involved, but also of many smaller nations, caught in the cross fire. Defence of these nations can only be achieved by co-operation and trust, with the inevitable backing of one or other of the super-powers.

It is fact that, 4% of all the British work force are employed in the Armed Forces—that about 5% of the G.N.P. is devoted to fuelling this "cold" furnace. More than a quarter of our total financial commitment to research is devoted to military science of one form or another. The expenditure of 7 billion pounds per annum on Defence, is exceeded only by that on Social Services, Health and Welfare and Education in our list of national priorities.

The questions remain: What do we achieve for this vast monetary outlay? What sort of threat are they designed to counter? Indeed, is any defence of Britain possible in this era of nuclear weapons?

Perhaps the greatest tragedy is the realisation that the need for such heavy financial commitment to defence is based primarily upon "Intentions"; the unknown intentions of potentially aggressive powers, and in particular Russia.

The defence operations of Europe; capable of meeting the Soviet challenge, are now heavily dependent upon American support, in addition to the establishment of the North Atlantic Treaty Organisation. One can only speculate on the impact of the withdrawal of American support.

With increasing urgency, Britain must ask how long can we support our commitment to NATO and what sort of alternatives are open to us. Prof. Ranft believes that we will soon be unable, financially, to continue support for the treaty. Yet instead of honestly admitting such, we will "soldier" on, in the hope that some one else will pick up the pieces.

Mark Powlson, Professor Ranft and the New Quodlibet Chairman, Richard Trembath, discussing war over sherry.

Postscript: An unpleasant thought for Christmas

" . . . facts have to be faced, and one fact is that nuclear weapons are no longer necessarily complex, bulky, ungainly temperamental, or even scarce: they have become simple, easily transportable, precise, neatly packaged and available—typical products of modern technology . . ."[1] The leader writer of the B.M.J. encouraged us to think about the unthinkable earlier this month. The London boroughs faced facts two days before at a seminar on dealing with the aftermath of nuclear war organised by the Greater London Council. *The Times* reported, *"It was likely that two thirds of the population would survive nuclear attack . . . the government had 28 films ready for transmission on television to inform the public."*[2]

As Professor Ranft told the Quodlibet Society, *"we live in a strange world".*

1. *British Medical Journal,* 1978. 2. 1248.
2. *Times,* Friday, Nov. 3rd, 1978.

R. D. LAING

24th October, 1978

Quodlibet kicked off its autumn season of lectures in grand style by evoking the well-known and controversial psychiatrist, R. D. Laing, to speak. The magnitude of the audience had to be seen to be believed. Never, can I recall, has the Anatomy Theatre been quite so packed. Indeed, the guru himself tripped over one of the many sardines huddled on the floor.

What we heard was a rather guarded version of Laing's highly personal view of psychosis. Perhaps the presence of a critical medical audience toned down the speaker's argument, for I doubt that the most conventional psychiatrist would have found much there to quarrel with. Nevertheless, it was fascinating to hear Laing's belief that in a small minority of cases, the best way of dealing with a psychotic episode is to allow it to evolve unchecked.

Early in the 1960's, after some years of observing schizophrenics, Laing came to the conclusion that sometimes a psychotic state becomes intelligible if you know how to read it. Furthermore, the process of distintegration could be viewed, on some occasions at least, as a way of resolving an impossible dilemma. This is no new idea. Gregory Bateson, in his paper, "Towards a theory of schizophrenia", published in 1956, expounded the notion of psychosis as a breakdown in communications. Life is full of contradictions and incompatabilities which not all of us can tolerate. Laing admitted there may well be a genetic predisposition to psychosis. Initiation ceremonies are commonplace in primitive communities and may be seen as a means by which a person's identity can disintegrate and then be born anew. Our society not only lacks these devices but is totally orientated towards suppressing the earliest manifestations of madness. We do not tolerate bizarre behaviour but instead attempt to extinguish it by drugs and in the past by more ruthless treatments. The vast majority of mental hospitals impose regimented biorhythms on their inmates. Patients must all eat, sleep and engage in the daily activities at the specified times. According to Laing, we impose a rigid environment on the people in our society who can least adapt to change and in so doing convert some psychoses from a positive to a negative functional state.

Laing then went on to discuss a very unusual case of a woman with recurring psychotic episodes which illustrated very nicely how different management can completely alter the outcome of abnormal mental states. Drugs and E.C.T. merely suppressed her madness and for 10 years she lived a robot-like existence. She felt psychically dead, nothing more than an empty shell and this caused her deep unhappiness. When one day she sensed the full blast of her illness returning she made no attempt to resist it but allowed it to evolve naturally. After two days of living through this extraordinary experience she emerged a new person and felt inwardly alive once more. A nice example but what sort of percentage of psychotic patients would benefit from such timely non-intervention? We need to do the research to find out.

C. M. Haw.

Forthcoming programme

16th January, 1979

5.30 Sir Charles Curran (former Director-General of the B.B.C.).

5.45 Lecture: *"The B.B.C. in retrospect."* Tower Lecture Theatre.

**February*

Dr. Martin Cole, Institute of Sex Education.

Director of Sex education film "Growing Up".

Title to be announced.

**March*

Mr. Harold Evans, Editor of *The Sunday Times*.

"Ongoing Situations" (not referring to Fleet Street industrial disputes, but to the misuse and abuse of the English language.)

*Dates to be announced.

Anybody wishing to meet any of these speakers or with suggestions for suitable speakers for future meetings should contact Richard Trembath (Chairman) via the Quodlibet pigeonhole in Boland House.

Three new films are worth seeing this month. **Eyes of Laura Mars** is a thriller starring the mature but gorgeous Faye Dunaway—who could ever forget Bonnie and Clyde? She has had a recent upsurge in her career with the well acclaimed but tedious Network. In this thriller she portrays the glamorous Laura Mars who is a fashion photographer with psychic powers enabling her to see through a killer's eyes. The killer murders her work associates one by one, and the climax of course occurs as he goes for her. If this were a T.V. film you might think your licence good value but I was a bit disappointed after paying two pounds to see it. However, it is a good thriller with genuinely frightening moments if you find it at a cheap cinema near you.

Watership Down is a beautiful film if you are a cartoon fan like myself. The mark of a good cartoon is the quality of the background scenery—and this is excellent. If you like a good cartoon and want an evening of escapism the film of Richard Adam's book is just for you. A mediocre story line with fair dialogue the only real character in the film is the seagull Heeha who as he crash lands into the undergrowth looks round to see nobody is watching and states firmly to no one in particular, "A perfect landing!" Watership Down is a film of many excellent parts and is well worth seeing.

Coma is a film with special medical interest to us all. It is about the use of human organs as saleable items—surely very topical. It is also one of the best thrillers of the year so far. It is always dramatic as a lady houseperson tries to find out why patients keep going into coma on the operating table. She succeeds in unravelling a very complicated mystery in most thrilling style and you will find yourself on the edge of your seat right until the end. I gather it is rather spoiled if you have read the book as the plot is very similar. However, the dialogue is witty—

hence the pathologist who as he explains the best way to murder people says its this information that keeps his wife on her toes. So if you have any spare time before Xmas— see Coma.

Two films that have been reborn for the Xmas season are **Tommy** and **The Sound of Music.** The former is an excellent musical for any Who fans and the latter I refuse to see on principal. I hope your hills are alive this Christmas.

J. J. E.

Nursing

THE INTEGRITY OF NURSES

At a recent legal hearing, four nurses were acquitted of a charge of stealing from their hospital, and the statement made that they had only borrowed the items and been somewhat slow in returning them. The health authority were at the same time, chastised for not having publicised a policy regarding the removal of hospital property.

The nurses concerned were delighted by the verdict declaring their characters unscathed which was widely publicised. However, this situation does leave one wondering just how far the limits of honesty can be extended and what standard should be expected from those whose work involves their dealing with people who are, to say the least vulnerable and who have the right to expect the highest level of integrity from all with whom they come in contact. Some consider that it is a well known fact that nurses have always assumed that they are entitled to remove certain property from the hospital, and have done so with impunity. They are, of course, no different to employees in all walks of life, but nevertheless, this raises the question as to how far this attitude should be condoned, and can the dividing lines, between honesty and dishonesty really be so ill defined.

It is incredible to think that nurses genuinely feel that they are entitled to furnish and equip their residences with items which they have not purchased. Not only is this dishonest, but demonstrates total irresponsibility of attitude, and lack of loyalty towards their employers, who are, to say the least in an impecunious state. Is it really acceptable for a judge to actually condone theft, even if the accused are those individuals who, in the eyes of the public are "angels in white caps"? During childhood everyone should learn that one cannot appropriate the property of others, and this standard should continue throughout life, despite the circumstances. Although it is probably unlikely that the accused nurses would take belongings from their patients, and would expres their displeasure were anyone to suggest that they might do so, it has to be accepted that there is reason for them to be suspected of this.

There cannot be attitudes towards honesty which differ according to the circumstances. It is an area in which there cannot be shades of grey, but only black and white. Nurses must accept that they cannot steal from their employers without the risk of retribution. Is it, therefore, really incumbent on the Health Authorities to have the words of the eighth Commandment prominently displayed throughout the hospitals in order that some sense of honesty is instilled in the employees?

Pam Jeffries.

Physiotherapy

There I was—en route to Leeds—surrounded by positive evidence that the thin man who allegedly lives inside his fat counterpart and is trying to get out, is manifestly failing, and that, furthermore, his host shows little sign of helping him to succeed. Assiduous reading of a succession of children's books about Gaulish France—I didn't get where I am today without studying Asterix—left me musing about the Roman family Gluteus, with their three boys Minimus, Medius and Maximus, but I was wrenched from the displeasing prospect of such monumental backsides by a phrase in the C.N.A.A. submission that was supposed to be the primary object of my attention. Or, to be more exact I was drawn into the vacuum of its absence, because there, neat and tidy as the educational wallahs are said to like it, were all the aims and objectives (which are, one discovers, not synonymous in this context) of this particular proposition. And among them, alarmingly, was this black hole.

What had, it seems, imploded was the concept that physio's should be taught to be therapists. There was this super course—4 years of it—with anatomy and physiology, physics and pathology, human science (that's a new one) and assessments galore—but where was the therapy? Well, to be fair, there was an element of practical work—to be even fairer, quite a large element in terms of total course timing, though nothing like the size that we currently have in our own three year course.

What will they do, these new physiotherapists? They will be bored out of their expanding minds, poor things, by all these frills and fancies, and will be seething with frustrated let's-get-my-hands-on-him (therapeutically) zest by the time they're done. Perhaps that's the idea, of course. . . .

Where do we stand in this graduate physio business? Well, there seem to be more degrees in Heaven and Earth than were thought of in Celsius' philosophy, let alone Hamlet's, so if them, why not us? But, for the sake of the patient, let us—and our paramedical colleagues—keep matters in perspective. No doubt the validating body will be asking this question—certainly the funding D.H.S.S. will—what does a four-year degree course produce that is better (and more cost-effective) than a three-year diploma course? On the face of it, our presumptively thin three-year student is larding herself with the avoirdupois of a superfluous fourth year. Is this excess bulk or is it the extra professional muscle that is needed to carry the newly-graven menhirs that Obelix so easily handles?

We in the profession, and you who use our services and skills, need to have an opinion, or better still, like the Chairman asks in the Location of Offices ad., the facts. Wait awhile, if you would. A little caution is called for because it will put us back twenty years if overhasty judgements are made or plans put into action. There is a good case, don't let's spoil it by over-anxiety, and don't let's confuse the general with the particular.

Ronald Cooper.

Book Reviews

"Forty Years of Murder", by Professor Keith Simpson. Pp. 328. Price £6.95. Published by Harrap, London.

Keith Simpson is a true star of Guy's. Of Scottish descent, his father was a G.P. in Brighton where Keith was raised. He went to Brighton Grammar School, thence to Guy's as a medical student, where he remained as prize-winning graduate in medicine and science, teacher and finally Professor of Forensic Medicine until his retirement in 1973. He is still professionally active and can be seen in the Common Room looking remarkably young and, fortunately for us all, willing to talk about any of his cases. His students and others who have had the good luck to hear him lecture will find the more spectacular and famous of these cases with very many others, illustrated by photographs, in the present book. It is literally packed with stories of crime, particularly accounts of the forensic and other findings and of their sequels, usually in court.

Keith loves teaching and the friendship it brings; his lectures are concise, free from irritating mannerisms and cliches and marked by a dry, perhaps rather black, humour. So it is with the writing here: little time is wasted in idle chat, all is fact with some shrewd advice on how to give medical evidence. On this score, perhaps the saddest tale is that of that good and kind Guy's physician Arthur Douthwaite who was led to say in court in the Bodkin Adams case that Adams must have given heroin and morphia to his elderly patient with "the intention . . . to terminate her life". For his, the lawyers tore Douthwaite to pieces and gravely damaged his reputation: Adams was acquitted.

This book will be an excellent Christmas present for those who like to hear about crime, as indeed many of us do: like children we love to be told about other, naughtier, people and what awful things happened to them. There is nothing salacious here though; the text is often frank but one never feels that detail is given for sensation, only as an attempt to elucidate the truth. Keith says "there is no place for deception or dishonesty in a calling that is dedicated to the discovery of truth. Diplomatic and political considerations should never be allowed to impede or divert medico-legal experts from their duty to try to find out what really happened, no matter whose feelings or prestige may be hurt". This opinion, expressed in Budapest, earned him a lecture from the authorities and, when put into practice (from Keith's kindness) in a case of accidental death in Portugal, a ridiculous wigging from a "dignitary" at our own Foreign Office.

The subtitle of Keith's book is "An Autobiography" but the reader will have to read carefully to find out much about his private life, apart from the details given above and some account of his early days. He tells us that his first wife died of multiple sclerosis and his second, twenty years later, of cancer but there is little about his family life or of the grief these cruel blows must have caused. Perhaps Keith's professional life is to him most important; certainly he gives us his own involvement and the excitement of his forensic work.

Here is a first-hand account by one of the few men, who, starting in the thirties when "standards of work were deplorably low", have made forensic science a most vital part of crime detection. Keith Simpson is now an outstanding international authority and this book is a personal report of the experiences of a man of rare and remarkable talent. It is not to be missed.

G. A. D. H.

"Friedrich Schiller; Medicine, Psychology and Literature", by Kenneth Dewhurst and Nigel Reeves. Pp. 413. Price £12.00. Published by Sandford.

Friedrich Schiller's major place in literature rests on his philosophical essays, his poetry, particularly the "Laura" poems but especially on his historical and political plays His writing is usually considered to have been mainly influenced by the philosophy of Kant with its major themes of transcendental freedom and the rejection of empirical ethics. Yet, Schiller's aesthetic productions commenced late in his life. Before that he studied and practiced medicine for 7 years giving the profession up for writing in 1782 when he was 23. In this book, Kenneth Dewhurst and Nigel Reeves set themselves the task of showing that these early years, largely ignored or de-emphasised in previous biographies or analyses of Schiller, had a crucial influence on the development of his thought and work.

The book is in four parts. The first describes his early years as a medical student and doctor. The second outlines

the prevailing medical and psychological theories of the time. The third section forms the kernel of the book and consists of the first annotated English translation of some of his medical and psychological works. The last section, Literature Philosophy and Aesthetics, re-examines Schiller's work to demonstrate the influence of his medical studies and development on his poetry, dramas and essays.

For the medically inclined, the first three sections are of principal interest. The book is beautifully written and massively researched. Dewhurst and Reeves' description of medical education of the day is of considerable fascination. They trace Schiller's development through the remarkable army medical school tyrannically run by Karl Eugen. The second theoretical section is an accomplished, concise analysis of the many strands of 18th century medical and psychological thought. It contains much of interest for the physiologist and psychologist and deserves to stand on it's own.

Schiller's first dissertation "The Philosophy of Physiology" was rejected by his academy ("the ideas are profuse and agitated" ". . . lengthy and tiresome treatise . . .") The second treatise "On the difference between inflamatory and putrid fevers" was also rejected but the third "Essay on the connection between the Animal and Spiritual Nature of Man" was accepted

The appended comments and analyses are meticulous and scholarly.

I do not think, however, that the authors are entirely convincing in establishing the importance of Schiller's own medical influences for his later work. The reason is that medical education could scarcely be separated from the general ferment of ideas prevalent at the time. It is conceivable that Schiller's own philosophical influences could have been obtained elsewhere. On the other hand, his personal experiences at Eugen's academy were remarkable in their extremes of rigid, occasionally brutal, regimentation, academic experiment and excitement, and personal frustration and unhappiness. These are certainly experiences which seem to have their echo in the themes of his early poems and particularly the "Sturm and Drang" dramas.

Above all, this book demonstrates the remarkable cross-fertilization of 18th Century religious ideas, philosophy and direct observation that was resulting in the emergent medical disciplines. It is a great pleasure to read and is highly recommended to those with an interest in the history of our profession.

B. ROSEN.
Department of Psychiatry.

"A Pathology Primer" in Verse, by L. H. Sobin. Pp. 37. Price £2.00. Published by H. K. Lewis, 1978.

Dr. Sobin has written a book
about Path., so give it a look
It is written in verse
deals with tumours and worse
then compares them with things that we cook.

The result is a pleasing anthology
which covers the basic pathology
the total endeavour
is really quite clever
and you might even learn some pathology.

DAVID TURNER,
Reader, Department of Pathology.

"Obstetrics and Gynaecology", by R. W. Taylor and M. G. Brush. Pp. 220. Price £2.95 Published by Balliere Tindall, London

This soft-covered book is one of the Concise Medical Textbooks series. It takes into account the change in emphasis in undergraduate teaching from a detailed consideration of obstetric abnormality and gynaecological disease to a broader view based on anatomy, physiology and embryonic development. There are chapters on the pathology of pregnancy, the pathology of labour, the unhealthy mother and the abnormal puerperium; on menstrual abnormalities, contraception and normal and abnormal sexual relationships; and on maternal and perinatal mortality. The book is readable, concise and clear. Because of its length much of the material is dogmatic but there is nothing with which the reviewer disagrees. The gynaecological section at the end of the book is very short, 26 pages, preceded by chapters at the beginning on ovarian and sexual function.

The book can be strongly recommended to the student who wants a short overall view of the subjects on the understanding that he will obtain further details from lectures, bed-side teaching and further reading.

T. L. T. LEWIS.
Consultant, Dept. of Obstetrics
and Gynaecology.

"Realities in Childbearing", by M. L. Moore. Pp. 772. Price £10.50. Published by Saunders, 1978.

The "realities" are facts, opinions and impressions which the author considers necessary in the training and practice of the nurse (not midwife). The text concerns almost exclusively the American scene. Definitions of stillbirths, parity, abortion, perinatal mortality etc. differ from those in England—problems of the Appalachian Mountain people, the die-

tary problems of the Deep South, the psycho-social problems of the counter-culture and the Navajo Indians make interesting reading. The book is designed for those who will have to deliver only in emergencies and much of it discusses nurses' attitudes to the "pre-natal family", the "intrapartum problem" and the "post-partum family". It suggests wrongly that there is considerable conflict between nursing and obstetric care and traditional and consumer orientated practice (e.g. Leboyer, Grantley Dick Read, psychoprophylaxis and home delivery). Emotions are classified in a teutonic way (lists of expected responses in various situations) and one wonders how much this is related to a desire to provide a degree course rather than to provide practical help. We have for example discussions of the "norms of the nurse as a person" and the "norms of a nurse as a nurse" which are rather pretentious. The diagrams are mostly excellent, the majority being taken from other standard texts though it is difficult in this context to accept a detailed diagram of the hypothalamic and pituitary nuclei in a book which lumps together occipito-posterior vertex and sacro-posterior breech presentation under "posterior position" and states that engagement is defined as occuring when the presenting part is at station zero (which is obviously not true in face presentation). I was surprised to see Hegar's sign described and illustrated. This is potentially dangerous. Doppler ultrasound is not suggested as a means of hearing the early fetal heart. The author is longwinded. "The beginnings of transition to parenting" is one sub-heading. The statements that "verbalization of feelings is largely a middle class value and a value of our profession"; "films emphasizing husband participation would not be a good choice for a group of single mothers"; "exercise that leads to fatigue exhaustion is *too much*" are cumbersome and self-evident. I would be happier were we not told that haemoglobin is often re-evaluated at 8 months gestation and think the book more up to date if there were not an illustration of an outlet pelvic assessment being performed at the initial visit using a Thoms pelvimeter!

Who could benefit from this book? I think it useful for tutors interested in developments across the water and it may become more relevant here if midwifery becomes closely integrated with general nursing (particularly if the desire for degree courses in nursing leads to training becoming progressively more theoretical and less practical). It is not a book for midwives in training or medical students.

E. D. MORRIS.

"An Introduction to Medical Genetics", by J. A. Fraser Roberts and M. E. Pembrey. 7th Edition. Pp. 324. Price £5.50. Published by Oxford Medical Publications, 1978.

More than a generation has passed since the first edition of this very useful book appeared. From the beginning the approach has been to keep formal genetics to the sufficient minimum to explain the wealth of examples in the field of medical genetics described throughout the text. These conditions are so described as to be useful to the student and general practitioner and the non-medically qualified geneticist. The mathematics have been kept in a low key, perhaps reflecting the decades when most medical students were not renowned for their mathematical ability.

This 7th edition differs from previous ones in that Marcus Pembrey is a co-author, but no chapters or topics are specifically ascribed to him. The chapter on blood groups has been re-written and the genetics of histocompatibility are now included; other chapters have been up-dated by the addition of recent advances. There is also a completely new chapter on molecular genetics. The general lay-out of the book is basically the same as in previous editions.

The impression that a book makes on a reviewer is clearly a function not only of the book but also of the reviewer! The new chapter on molecular genetics begins with an account of transcription and translation illustrated by an "amusing diagram for which we are indebted to Professor H. Lehman and Dr. R. G. Huntsman"; amusing perhaps, but I found it far from self-explanatory and the text did not help me much. This is followed by an excellent account of the haemoglobinopathies including rare ones, their coding and the mechanisms of terminator mutation, frame-shift mutation and "unequal crossing-over" mutation. I found the rather "tight" style of writing required considerable concentration to be understood. This applies also to the account of the genetics of the main histocompatibility complex (HLA). More about polymorphism at the H2 locus and the possible clinical importance of these genes would have been welcome.

The revised chapter on chromosome anomalies is excellent. The normal human karyotype is described together with a diagram showing regions and band numbers as suggested at the Paris conference. There are good descriptions of clinical chromosomal disorders together with excellent corresponding karyotoypes, some of which are new. There is a short section on chromosome mutation (which could with advantage be fuller) and mention is made of DNA repair systems.

The chapter on multifactorial inheritance I found disappointing. "Multifactorial inheritance" is often loosely used by geneticists. The purely arbitrary distinction made by Carter between polygenic inheritance (where environmental factors play no or a minimal role) and multifactorial inheritance (where the intra-uterine and perinatal environment may precipitate the abnormality) makes for greater clarity. The analogy of coin tosses to the way in which continuous variation is determined by polygenes is clear, but today's students are more mathematical than those of past decades and usually receive tuition in simple statistics, and a fuller algebraic explanation could perhaps be substituted here with advantage. Congenital malformations are relatively so common in the population that a much fuller treatment would have been welcome. Research is currently going on into alternative possible explanations of some conditions generally accepted as multifactorial; it is therefore surprising that congenital dislocation of the hip, which is the best documented example of multifactorial inheritance, is not discussed. A short section on twin studies has been inserted between polygenic inheritance and congenital malformations but there is only a brief reference to their significance in continuous variation. It is refreshing to be warned of the tendency to overvalue twin studies (it has recently been calculated that at least 33 twin pairs are needed for statistical validity and as many as 88 pairs for rare conditions). Nevertheless the use of twin studies in adjudging the "strength" and the aetiology of genetic causation would be a welcome addition.

The book ends with some wise comments on the giving of genetic advice. There is a useful list of references, an index of definitions and a subject index which is rather more complete than in previous editions.

The 7th edition of any book demands not only some re-writing to bring it up to date, which has been done splendidly, but also the insertion of totally new material. This intercalation has been skilfully done, but dare one hope that the next edition will be a complete rewrite so that the integration of both factual material and style will be complete, and that a simple mathematical approach will be made to probability, family pedigree analysis and the analysis of a polygenic system.

The book remains one of the best on this difficult subject and is outstanding for its general clarity and the enormous amount of medical information which it contains. Students of today who tomorrow as G.P.s will be asked questions relating to medical genetics cannot afford to be without the book which remains a "must" for medical and reference libraries.

B. J. RICKARD,
Biology Department.

"How to lose weight without really dieting", by M. Spira. Pp. 224. Price 80p. Published by Penguin, 1978.

From the title one would expect an easy answer to weight loss and to this extent the title may be misleading. In fact this book is entirely for the lay-person and the bulk of its contents are simple descriptions of metabolism, normal and diseased. The topics covered are wide-ranging and thinly related to losing weight. There are only few errors of fact and perhaps the next edition will correct the statements that body fat can be converted to glucose, that calcium deficiency causes rickets and that sucrose is very fattening.

It has taken the author 224 pages and cost the reader 80p to be told that the principle of the diet therapy recommended is to eat a little less.

I. MACDONALD,
Professor, Department of Physiology.

"Regional Anatomy: Multiple Choice Questions", by T. R. Murphy. Pp. 158. Price £3.50 Published by Lloyd-Luke, 1978.

As its sub-sub-title states this useful little paperback is "for self-assessment and self-improvement". Although it is based upon the "multiple choice" technique, it is so constructed as to oblige the reader to learn as well as to remember. All regions are covered. On head and neck alone 80 topics are covered—each with five questions, the whole book containing, in essence, 1,665 questions. Admittedly, these are all short, almost entirely factual, there being the usual absence of any call for protracted answering reasoning. Real situations do not invariably call for monosyllalic "True" or "False" responses but, with this proviso, the book is an excellent source of anatomical quizzing. It is aimed at medical students and postgraduates. According to skill, each of 70+ pages could be completed in 1-5 minutes, so that a single day of revision could take a reader through most of the body, and few could fail to profit.

Some of the questions seem trivial and even unnecessary, and the whole approach (in terms of content) is conven-

tional. No concepts are tested. The author is a professional anatomist (University of St. Andrews). Nevertheless, the method is a useful departure from usual M.C.Q. technique, and as a means of self-testing it is to be recommended.

ROGER WARWICK.
Professor, Dept. of Anatomy.

"Sectional Dentures", by Pullen-Warner and P. R. L'Estrange. Pp. 136. Price £6.25. Published by Wright & Sons, 1978.

This book is the result of many years of work by the authors, who are both pioneers in this field.

The use of two part prostheses facilitates the restoration of the whole of the edentulous span, including those areas below the supra-bulge of the abutments. There is therefore no space for gingival proliferation and false pocket formation, and with anterior restorations a more aesthetic result may be obtained. Once inserted, a positive method of uniting the components obviates the need for conventional clasps. Much of the text is concerned with the construction of the "denture bolt", "the split post" and "the rotopont hinge" methods of union.

The book is essentially a technical manual with a limited clinical content.

It comprises 136 pages and 276 illustrations, bound in cloth.

The black and white photographs are mostly of good quality. The numerous line drawings, many of them by Mr. Pullen-Warner, are excellent. Much care has been taken to site the illustrations close to the appropriate part of the text.

There are twelve chapters covering terminology, indications, the various designs and maintenance.

This is the authoritative work and will be of immense value to all those involved in the production of Sectional Dentures.

W. A. V. BEARE.
Lecturer, Dept. of Prosthetic Dentistry.

"Removable Partial Denture construction", by John F. Bates. Pp. 151. Price £12.25. Published by John Wright & Sons, 1978.

Professor Bates' name is a well respected one in British prosthodontics and perhaps the only real surprise about the second edition of his book is that it should have had an eight year gestation period.

The text is aimed at dental undergraduates and technical students studying for the final City and Guilds examination. Whilst it is of undoubted value to both categories such is the variation in style of the respective examinations that, as one may surmise, there is not quite enough in the book for one group and a little too much for the other.

The undoubted criticism of the first edition was a heavy leaning towards the technical aspects of partial denture construction. In his preface to the second edition, Professor Bates recognises this and mentions that he has attempted to correct the bias by expanding the chapters on partial denture design and treatment planning. In any more general text, the author's particular interest can often be identified by some disproportion in its allotted space. Professor Bates' particular interest has been in the alloys used in partial dentures and their influence on component design. This material was particularly prominent in the first edition, accentuated by the restricted discussion of the clinical aspect of partial denture procedures. The additions to the text do redress the balance of the new edition (thus bringing it into line with another work more familiar to Guys students), whilst retaining the value of the author's special knowledge.

The book deals mainly with metal based designs, but Chapter 11 is devoted to acrylic dentures having some metal components. The closing chapters (12 and 13) contain descriptions of methods for periodontal splinting in partial dentures, 2-part dentures, alterations and repairs and an introduction to precision attachments. In this last chapter there is an indication that the revision of the text has not been uniformly thorough. The Zest anchorage system has been introduced since the first edition of the book was published and is included in the second. Another development which occurred as far back as 1971 was that Cendres and Metaux (the major producers of prefabricated attachments) introduced a new classification with a complete change of cataloguing numbers. Former reference numbers are still used in the new edition.

There are some useful recommendations for further reading which are not too numerous to deter. It is noticeable, however, that in the established chapters of the book the only updating of references has been by the addition of papers emanating from the appropriate department of the Welsh National School of Medicine.

So far as production features are concerned some of the photographs are dark and lack contrast, but the double column format enables text and illustrations to be presented in close association. The book is bound in limp cloth and there is an adequate index.

The new edition of Professor Bates' book is already in the library and will repay investigation. Do not approach it without critical faculties well honed however—for example the like of Fig. 41 should not be regarded with too much favour if the reader is looking for guidance on supporting tooth and mucosal borne upper dentures.

J. D. WALTER.
Consultant, Dept. of Prosthetic Dentistry.

"Intra-oral Radiographic Interpretation", by R. P. Langlais and M. J. Kasle. Pp. 147. Price £8.00. Published by Saunders, 1978.

This is a refreshing book on dental radiology, and is the first volume of a proposed series of exercises in dental radiology.

Produced as a quiz-type presentation of 287 intra-oral radiographs, volume one has succeeded to a large degree in overcoming the usual problems of radiographic reproduction.

By enlarging the figures to the ideal size for interpretation and placing arrows accurately, assessment of the radiographs is made straightforward. Radiographs have been selected carefully for good reproduction and the paper quality is good.

The paper-back volume comprises five sections: normal anatomic structures; film handling and processing errors; identification of materials and foreign objects; developmental anomalies and pathological entities, and a special technique (parallax) used for location.

A comprehensive answer section is supplied at the end of the book.

The question and answer format is a success, though some answers require elaboration. The British reader may find such comments as: "Welcome back. Ready to start again? Here we go" somewhat irritating. Fortunately these irritants are not too frequent!

It is regretable that Figures 4.21 and 4.56 have been printed upside down as the text is correct.

This is an ideal book for revision purposes, as the radiographs selected are representative of many of the conditions found in general dentistry.

The quiz pattern is stimulating and this book can be recommended as a "refresher course" for both student and practitioner. The price reflects the number of illustrations and is realistic at £8.00.

B. W. BEECHING.
Director, Dept. of Dental Radiology.

"Coronary Care in the Community", Ed. Dr. Aubrey Colling. Pp. 226. Price £12.95. Published by Croom Helm, 1977.

This stimulating though rather expensive book is based on the proceedings of a national workshop on coronary care. The workshop was organised after a survey in Teeside raised further doubts about the benefits to be gained from coronary care units (CCU's). They found that even after taking into account the patients' age and sex and the severity of the attack people appeared to do equally well, if not better, at home. Similar findings and the growing literature on both the importance of speedy treatment and the peril of frenzied transfer to hospital led the editor to believe that general practitioners might welcome advice as to appropriate forms of care.

The aims of the workshop, to gather evidence from those active in coronary care and to formulate guidelines for primary physicians, form the twin thrusts of the book, which has four parts. The first contains an epidemiological review of the effectiveness of different kinds of care for acute myocardial infarction and a fairly extensive report of the Teeside Coronary Survey. The second comprises reports from those with experience of forms of care such as mobile units, home care and care in the industrial work place. Part three has the guide-lines for GP's with the advice varying according to the proximity and availability of CCU's, mobile units and cottage hospitals. (It is interesting to note that there was a fair measure of agreement on these among those working in general practice, CCU's and those with mobile care units.) Finally rehabilitation and prevention are at least given an airing—but apparently merit only 20 pages out of 220!

The emphasis of the book, particularly in giving guide-lines, is not to suggest strategies for coping while assuming that coronary care facilities are inadequate, but to stress that the provision of services and arrangements for care should be based on the consideration of what is appropriate *given the local situation*. As such it should be of great benefit to those interested in health planning whether they be doctors, "health planners", CHC members or others. But therein lies the major criticism, not so much of this book but of the approach to coronary care which it symbolizes. Of course we need the best treatment and care but I worry that while we are so busy wading through the statistics and deciding which is best, we will forget the possibilities for prevention. In one of the studies quoted, nearly 50% of the deaths in the first four weeks

occurred in the first two hours. In the same study the median time it took the patient to contact the GP was 104 minutes and the average time it took the GP to reach the patient 51 minutes. The total of almost 2½ hours explains the plea for haste but leaves the 50% mortality figure untouched. What might prevention contribute?

While the package suggested by the editor for the prevention of coronary thrombosis is excellent, its impact is likely to be reduced by the type of thinking displayed elsewhere in the book. One contributor finds it impossible to think that a particular treatment has not affected mortality, even though statisticians cannot prove it, and asks us on that basis to accept that intensive care is valuable. It may be that such treatment could result in a 3 or 5 per cent reduction in overall mortality but what might be done for the 50% who die in the first two hours if the resources it uses were devoted to prevention?

After reviewing the effectiveness of care of different types Professor Acheson rather sanguinely comments "I suspect that I shall look to general practice if I have my coronary at home". I suspect that after reading the book, which they should, many others will not disagree with him.

JOHN DENNIS.

Unit for the Study of
Health Policy.

"Abbreviations in Medicine", 4th edition, by E. B. Steen. Pp. 136. Price: £2.50. Published by Baillière Tindall 1978.

A dictionary of abbreviations is invaluable in these days of VAT, the EEC and UFOs. However a book of medical abbreviations is particularly welcome, as the bewildered medical student or medical secretary must know.

This book is still flavoured by its American origins, and it is aimed particularly at lay people who may find difficulty in reading medical records. Those of us who use such terms as PERLA, NAD or TVF tend to suppose that we will always be understood, whereas to the uninitiated it is the veriest rubbish. *Abbreviations in Medicine* provides the key.

Doctors are often ignorant of the origin of their shorthand. It is good to discover for example what PRN really means. A further, and particularly useful function of the book is to attempt to standardise medical abbreviations.

In summary, a useful book for the Doctor, Medical Student or Medical Secretary.

RICHARD HENDERSON.
House Officer.

"Aids to Undergraduate Surgery", by P. M. Mowschenson. Pp. 144. Price £2.50. Published by Churchill Livingstone, 1978.

It is particularly pleasant to be able to greet a new textbook by a Guy's man, especially when the product is so easy on the pocket both in respect to expenditure and transport. However its very slimness may be a ground for criticism. "Many a book would be shorter if it were not so short" wrote Emmanuel Kant in a period of unusual lucidity, and this is nowhere more true than in relation to the "lecture notes" type of medical textbook where sheer lack of illustration makes the book dry and unpalatable and the facts hard to learn.

Nevertheless, the book is a useful syllabus—outlining the approximate range of facts required in the written final B.S. papers—and as a source of last-minute revision. It is right up to date in some fields, though there are conspicuous gaps and some copyists and typographical errors which may confuse the unwary reader. It is sad to see the non-existent Dr. Duke being again credited for Dukes' staging, and disappointing that some clinically important areas not well dealt with in the standard textbooks, such as abdominal trauma, perioperative care and spinal compression are again dealt with sketchily.

When the book comes to its second or third edition it would be nice to see more line drawings to aid those with a visual memory, and a greater emphasis on the clinical approach rather than lists of causes and treatments. The newly qualified doctor requires to know not so much *what* the various features of disease are as *how* to sort them out in order not to make big mistakes. The mental facility needed to translate a list of causes of bowel obstruction (29), for example, into a rational plan of patient management is not possessed by ordinary intellects, nor is it necessary to remember the list in order to manage patients correctly. I look forward in future editions to a text which will make these clinical choices as clear and simple as in real-life surgery the majority are.

T. K. DAY,
Registrar, Dept. of Surgery.

Correspondence

Guy's Sport

Sir,

Dr. Reekie draws attention to the facetious reports of indifferently supported sports at Guy's.

Your balanced editorial rightly refers to the pride in hospital sport which appears to be the prerogative of previous generations.

Seeking the cause of this decline one can find many explanations but few remedies.

It could be that the study requirements of present day medicine and dentistry leave less time for sport. However, "*mens sana in corpore sano*" surely still applies. The body needs to be capable of effort and resistant to fatigue. This can best be gained by experience which finds its most enjoyable form in competitive sports. The benefits, in friendships and so many other ways, have so often been expressed as to need no reiteration.

This however, does not mean that hospital teams and any, but a few individuals, will be able to distinguish themselves as heretofore.

A professional attitude has entered into the field of sport (much to its detriment in my view), so that it is not possible for the student to devote the time necessary to get to the top and to do justice to his work at hospital too.

It follows that sport is for fun, as far as the Amateur is concerned but just messing about in a dilatory way is not to get the most out of it.

Let us see Guy's sides adequately represented, acquitting themselves at the best levels they can achieve. They will then be carrying on the great tradition.

Yours faithfully,

DUNCAN LYON.

12 Oxford Street,
Nottingham NG1 5BG.

Guy's Sport—The Remedy

Sir,

Dr. Ian Reekie's excellent letter bemoaning the standard of sporting commentary and the apathetic attitude to sport in the hospital at the present time prompts me to offer an explanation for the latter problem.

The Passim of the same issue intimated that selection procedures place a high degree of importance on academic achievement. This factor was debated by members of your interviewing panel for prospective Guy's students in an earlier *Gazelte* issue, and one member at least questioned whether students with very high "A" level grades necessarily made the best doctors. Some of us who spent many happy hours in the 1950's and early 60's turning out for Guy's sporting teams regularly week after week would possibly never have been accepted for interview on todays criteria (Thankfully grading of "A" level passes had not been introduced then).

Whilst I realise that to-day's students are beseiged with an ever-increasing workload perhaps a less academic intake who worked hard and played hard would still be able to satisfy the examiners, and would be proud to represent the Guy's sporting teams.

Yours faithfully,

PAUL SIEVERS.
(Guy's 1957–62)

Crestholme,
Well Meadows,
Shaw, Newbury,
Berkshire.

Professor Haslewood—A Refreshing Reply

Sir,

How refreshing to read Professor Haslewood's delightful letter.

I trust the Nursing Correspondent has found comfort in his mature and balanced outlook.

Yours faithfully,

LINDA R. S. TITLEY.

Friars Cottage,
Kingston, Nr. Lewes,
Sussex, BN7 3PD.

The 1928 Dining Club

Sir,

It may be of interest and value to some of your readers to learn of the following small celebration that took place in London last month.

A dining Club was formed in 1928 at Guy's amongst some newly qualified fourteen doctors. They have—except for the war years, met annually for exactly

fifty years for their initial pleasure and friendship.

Owing to increasing age—they are now in their seventies—it has been decided that Oct. 1978 should be the last gathering of these friends as their ranks are now thinning. Apart from the fact that these Guy's contemporaries have been good doctors—a degree in general practice, and much loved by their patients—they all have the distinction of having been happily married and have remained so over the years. Few—if any of these doctors could have afforded or been able to get married before they reached the age of 30 in those days. Is there a lesson to be learnt from this in these insecure and uncommitted times or is it still just a question of luck?

These doctors were trained by such great teachers as:— Sir Charles Symonds, Sir Arthur Hurst, Prof. John Ryle, John Fawcett, R. Davies-Colley and Sir J. Connybeare and of course—the sisters—to whom they owed a great deal.

All these doctors—except one—have now retired to well-earned recreation—a few are dead but let us hope that the remaining members of the Club will continue to keep in touch with each other.

Yours truly,

ELIZABETH R. SCOTT,

Holly Bank,
Peasemore,
Newbury, Berks.

Review reviewed

Sir,

David Armstrong's review of my book *Doctor and Patient in the Teaching Hospital* (28th April, 1978, page 162) first irritated, then amused, and finally confused me. He concludes that "The only thing obvious to my mind is that this book is truly awful." Which it may be—as an author one cannot claim to be an objective critic—but not for the reasons advanced.

Armstrong lists three ways of researching the doctor-patient relationship, and describes the second as being "to examine the doctor-patient relationship from the point of view of the belief systems of the two participants". He maintains (and appears to regret) that this approach has been ignored. What book did he read? Fully two-thirds of my book deals with *exactly* that—the effect of differing perceptions and beliefs on the part of doctors and patients about themselves and each other, about the purpose for which they meet in the hospital, about what health and illness really are, about emotion and pain and death. Granted that a reviewer may practice some degree of selectivity, why ignore six chapters of a nine chapter book?

Nor does a reviewer's right to be selective imply a right to misrepresent facts. Armstrong says "she (the author) offers neither questions nor interivews to her subjects. . . ." In fact, *all* patients and all doctors were interviewed, all more than once and many every day. This procedure is alluded to in the acknowledgements section (p. xiii), and near the end of Chapter One (page 13). It is mentioned repeatedly in Chapter Two, entitled The Process (see page 18, P1, line 4; page 18, P3, line 5; page 18, last line) and particularly in the section People: The Patients in this same chapter (pages 21-22). The category Silent Egalitarian, described in Chapter Three (page 26) could not have been created without this interview process. Again, what book did this reviewer read?

Armstrong's final point is that the conclusions offered in the book are already well-known. That may be so in Britain, and if it is then your medical educators are to be congratulated. We in the United States have not yet reached that utopian state.

Any book, even one's own, may be "truly awful" — and if it is then a reviewer should be commended for saying so. But I'm still confused; just what book did he read?

Yours very truly,

CECILIA M. ROBERTS, Ph.D.,
Associate Professor.

Department of Psychiatry,
The University of South Dakota,
Sioux Falls.

In defence of Horrobin

Sir,

I would like to answer briefly David Armstrong's review of "Medical Hubris: a reply to Iron Illich" by David Horrobin.

Illich makes many sound points of criticism of modern medicine but fails seriously to communicate his thoughts with ease and is often carried away by his revolutionary enthusiasm to include irrelevant facts, untruths and false arguments.

Horrobin clearly, concisely and accurately points out most of the faults in Illich's work and reassures the reader that all is not quite so rotten in the state of medicine as Illich would have us believe.

I would especially recommend Horrobin's book to those B.M.S. students who

found themselves in a state of self-doubt after reading Illich as part of David Armstrong's sociology course.

Yours faithfully,
ALAN BARKER,

c/o East Wing,
Guy's Hospital,
SE1 9RT.

Miss Rene Knight

Sir,

Miss Rene Knight retired on the 16th October after 26 years' service at Guy's.

There are few people who have worked so hard to give the Hospital a good reputation particularly with the families of the bereaved. Distressed, and often bewildered relatives of patients who died in the Hospital were looked after by her with unfailing courtesy and sympathy. Time and again, she sorted out their problems and went to endless trouble to make sure that they received a satisfactory explanation to their anxious questions. She never forgot that the loss of a loved one is a matter of major importance to those who are left behind.

She was one of the few remaining members of the Hospital whose long service has provided the backbone of its structure since the war. Her knowledge of Coroner's Court procedure was immense. The wise advice she gave to generations of raw and inexperienced house officers saved many of them from making a mistake which might otherwise have caused them serious embarrassment and the Hospital undesirable publicity.

I should like to take this opportunity of expressing my appreciation of the help she gave me personally during the years when I was Superintendent and to acknowledge the extent to which the Hospital is in her debt for the service she so willingly gave to it. I am sure her many friends join me in giving her their very best wishes for the future.

It is sad that her retirement should have been marked in such a casual fashion. To send out invitations to a farewell party four days before the event, duplicated on a plain sheet of paper and enclosed in a utility re-usable envelope, is little short of an insult. The shortness of the notice made it impossible for some to attend who would have liked to have done so, and the haphazard arrangements gave the impression that it was rather a routine occasion and did not give it the importance it deserved. I am making this point in the hope that this letter will be read by some who may have to arrange a similar function in the future. Perhaps they will realise that carelessness of this description causes much pain and bitterness and does not improve the image of our administration in any way.

PHILIP J. HELLIWELL.

"Brettes",
Monks Eleigh,
Suffolk.

St. Guy of Regents Park

Sir,

So poor Guy the gorilla is dead. He hit the headlines because his death was a consequence of having an excess of sweets thrown at him by an unthinking public. What an ignominious end for such a noble creature compelled by civilized society to exist in such degradation.

He was probably overweight too, but I doubt if there is a life insurance scale for gorillas to check against.

Our children also suffer from having an excess of sweets "thrown at them" by civilized society, by unthinking parents or relations or by those who profit from and encourage their innate craving for sweets and confections.

When compounded the quite unnecessary suffering of children from dental decay and the consequent need for tiresome and almost interminable treatment to allay greater suffering, is enormous.

Dental decay is not a disease in the true sense. It is a dietary injury, largely accepted by civilized society with considerable indifference and cynicism. As such it is a non-accidental injury. If similar injury was inflicted in any other way there would be hell to pay.

Let Guy be an example for us all to heed. His "martyrdom" under a hail of sweets will not then have been in vain!

W. I. N. FORREST.

16 Queen's Road,
Waterlooville, Hants.

Sport

RUGBY

Guy's 6pts., Osterley 12pts.

Guy's had a good record against Osterley before this fixture was played but began badly by conceding a try early on to a forward rush by Osterley, which was converted. Playing against the wind Guy's defence looked weak against very moderate opposition and only kicking failures by the Osterley full-back kept Guy's in the game until another Guy's tackling lapse let Osterley in for a try just before half time.

Switching 12—0 down Guy's were soon on the offensive with an early try by Broughton. Penalty and try scoring chances regularly went begging up until the final whistle. It was easy to see the Guy's players individually were easily a match for their opposite numbers but team work let us down. Let's hope the coaching sessions given by Iestyn Thomas of London Welsh will again see Guy's back in winning form.

Team: Parry, Gibson, Neill, Keevil, Beard, Brazier, Robertson, Laws, Broughton, Wilkinson, Mihill, Reece, Portelly, Tunnadine.

Guy's 16pts., O.M.T. 9pts.

A somewhat disorganised convoy of cars took Guy's to Old Merchant Taylors ground, and a somewhat disorganised team took the field. But some spirited play allowed Guy's to dominate the early exchanges and take the lead with a try by Wilkinson under the posts. Huw Williams, a fresher, waded in with an excellent solo try some 20 minutes later and Guy's look set to romp to victory, but the forward effort slackened, kicks were missed and O.M.T.'s scored a try to give them a chance once again.

The second half saw Guy's again applying consistent pressure until the O.M.T.'s defence was finally breached after Francis gave a somewhat risky "hospital" pass to Broughton who squirmed through a narrow gap to score. Guy's held on to this advantage but were never the confident and assured winners they should have been.

Team: Parry, Gibson, Neill, Keevil, Beard, Brazier, Robertson, Flanagan, Francis, Broughton, Wilkinson, Mihill, Portelly, Williams, Manning.

Guy's 3pts., Mountain Ash 51pts.

The record of closely fought encounters between these two sides was shattered on a freezing day in the Welsh valley village. Guy's looked travel weary from start to finish and could never hold the fast and enthusiastic opposition, for which their scrum-half incidentally was making his 500th appearance. The Guy's side never wanted to win the ball or tackle and several notable absentees from training sessions looked very unfit. Broughton kicked the solitary penalty for Guy's whose dismal performance kept a smile on the faces of a few hardy "Ash" supporters. Certainly next season Guy's will have a lot to do to earn the respect of this team again.

Team: Parry, Gibson, Neill, Keevil, Beard, Brazier, Flanagan, Robertson, Philips, Broughton, Wilkinson, Mihill, Williams, Portelly, Manning.

G.P.

SOCCER

1st XI report

At the time of writing the 1st XI are still looking for their first league win of the season. Early team problems were ironed out with Robin Evans moving into the goalkeeper's position, Andy Mitchell returning as sweeper and Gary Teader joining the team, all to good effect. However these changes made little difference to the overall team performance. A 2—2 draw against Bedford has been the only point obtained by a team suffering from a lack of confidence, enthusiasm and basic fitness. Spirits were seen to reach such a low ebb after a 6—2 defeat by L.S.E. that Eric Dan was even moved to buy a jug for the unfortunate losers—cheers Eric.

The full league analysis is:

v. U.C.H.	A	Lost	3—2
v. Chelsea	A	Lost	4—2
v. Bedford	H	Drew	2—2
v. L.S.E.	H	Lost	6—2
v. Goldsmiths	A	Lost	4—3
v. London	H	Lost	3—1

P	W	L	D	F	A	Pts.
6	0	5	1	12	22	1

Not having seen the league tables, it takes little astute calculation to realise that Guy's 1st XI lie somewhere near the foot of the premier league table.

Top league goalscorer is Mike (still searching for a middle name) Breeze with 4 goals, followed by Paul Shepherd (to whom I apologise for spelling his name incorrectly in the last article)

with 3 goals and then Gary Teader with 2 goals. Other league goalscorers each with 1 goal are Dave Abraham, John Rawcliffe and Dave Smalley.

The best league performance of the season was, surprisingly enough, against the giants, both in stature and reputation, of Bedford. It saw the appearance of a full strength side and Robin Evans playing his first game for the 1st XI. Rob distinguished himself in the first half with a brilliant dive to the left to save a curling shot from a Bedford forward and with solid goalkeeping throughout the match. The forward line kept the Bedford defence under constant pressure and after 20 minutes a clever ball from Trevor Underwood left Mike Breeze clear to fire the ball past the keeper. The midfield were industrious and the defence confident, for once, most probably due to the reappearance of Andy Mitchell in the back four. Another goal from Mike Breeze came early in the second half, heading in (a rare event) the rebound after a shot from Paul Shepherd had hit the crossbar. This saw Guy's go 2—0 ahead. A lack of concentration, so often a hallmark of the team's second half play at present, led to Bedford scoring two goals, one headed in from a corner, and one when the defence were distracted by a whistle blown on the adjacent hockey pitch. A draw in an enjoyable match which Guy's deserved to win. A mention must be given to Dave Abrahams who turned up as substitute and was denied the chance of possibly playing by an insane league ruling regarding substitution, which hopefully will be changed.

The U.L.U. cup showed more promise, there being a 4—1 win in the preliminary round against U.C.H. at H.O.P. Thus, the defeat of the first match of the season was reversed. Guy's were on top from the start, many chances coming to Gary Teader, Paul Shepherd, Mike Breeze and John Rawcliffe. The first goal came to John Rawcliffe, a spectacular shot from outside the box into the top left hand corner. Two further goals then followed in quick succession, the first from Paul Shepherd, a curling chip from the right side of the box. The second came from Mike Breeze, side footing the ball past the U.C.H. keeper after a low cross. 3—0 at half time. The second half saw another goal from Paul Shepherd, dribbling the ball past the stranded goalkeeper to score. There were many more chances, notably to Simon Perkins, who was unlucky not to score. U.C.H. scored a late goal past a lethargic defence to make the final score 4—1. However, following this, in the first round against Goldsmiths on a cold Saturday towards the end of November the team were defeated by the same score 4—1. The team displayed quite a mysterious inability to score and Goldsmiths were made to look special only due to the bad Guy's performance. The solitary goal was scored by Simon Perkins, his first goal of the season. Thus the First XI made their exit from the U.L.U. cup in a quite unceremonious fashion.

The performance in the first round of the U.H. cup was also unimpressive going down 5—2 at home to the London. Mike Breeze and Paul Shepherd (who else?) scored the Guy's goals.

The priority for the remainder of the season must be for points in the league to avoid relegation. None of the games this season will be easy. Things will be harder as the services of Ian Wilson have temporarily been lost and we look forward to his return.

Finally, awards so far this season must go to Dave Rees for "attempted home goal of the season" in the league match at Goldsmiths and Neil Maclaughlan for restraining his gastric contents in the U.L.U. cup match at the same ground. To Simon Perkins goes the "spot the ground" award for his astounding navigation on the team expeditions away from home notably the friendly at Q.M.C. and the first match at a church somewhere near the Goldsmiths ground.

BARREL.

Guy's 2nd XI Fail

Guy's Seconds recently failed to beat their highest scoring record against U.C. IV at H.O.P. It was a windy but otherwise fair day when the team took to the field led by "Father" Abraham and Graeme Smurf.

The first half saw Guy's stylishly build from a sound defence, combining well in midfield and scoring goals that would have been missed in earlier games. Guy's in short were superb. On this form they would have won the World Cup, beaten Liverpool and Nottingham Forest in the same week and perhaps even defeated the London II's. It was so good that the defence started to pass the ball **and** Davies didn't complain.

The goals came thick and fast—everyone got in the act (after Trev. Underwood had got his hat trick). 8 goals in the first half. Oranges were speedily devoured by all except Father Abraham who put his orange inside his boot to ward off blisters.

The second half started and U.C. attacked like men possessed (had Brian

Clough come to encourage them?). Guy's defence helped by Smalley stood firm, the rest of the midfield went for a siesta and the attack watched the defence at work. However Guy's were soon on top again, and scored five more in the last twenty minutes of the game. Don't ask Roger about the penalty—the referee kindly refused to let him retake it!

Credit must go to U.C. for not giving up until the final whistle—they were gallant losers, they could have been Guy's men.

A match in which Guy's played well in the first half and went to sleep in the second. However along the way they scored 13 goals. Scorers were Smalley 3, Underwood 3, Greenaway 2, Earnshaw 2, Davies, Abraham and Smith 1 each, and I didn't.

REVLAC.

HOCKEY

v. Deal. Home. Result: Won 3—1

A fine result against the runners-up in the league last year. At the start Guy's were very disorganised with Gulamali arriving late and they soon found themselves a goal down. However Guy's soon settled down to play some fluent hockey for the latter part of the first half and created many chances the majority of which were squandered carelessly with Jones being the main culprit. Hopefully he will improve his shooting as this cost him dearly afterwards. By half time we were 2—1 up with goals from Wyeth and Gulamali and early in the second half Niaj Karim made it 3—1 with a fine goal. Guy's continued to put pressure on the large vociferous Deal defence but Jones continued to miss the goal with monotonous regularity. Towards the end of the game we ran out of steam and allowed Deal to take command. The defence however soaked up the pressure admirably and although Pascoe sat on the ball in his own inimitable fashion giving away a penalty the final score remained 3—1.

v. The London Hospital. Lost 3—6. Away

On a pitch that made H.O.P. look like a corrugated iron roof Guy's started very strongly with a good goal resulting from Wyeth. The London however played very aggressively and soon hit back with a break down the right wing leaving Oastler in goal with little chance. Undisturbed by this Guy's continued to press forward with fine running from Bains and Karim at the front providing Wyeth with a chance which he accepted gratefully. Unfortunately the London hit back within minutes to level the score and just before half time a defensive error allowed them another goal to give them a lead 3—2. However after the break Guy's came back strongly and levelled the score 3—3 through a goal by Hett. At this point however our attack stopped running and the defence was reduced to complete shambles just handing three goals to the London on a plate. Not even Sanders attempts to destroy the goal could prevent a 6—3 defeat.

v. Edenbridge. Home. Result: Won 3—1

Another fine league win by the Hospital who played some very good hockey interspersed with some equally bad hockey. It is a pity that the side does not seem able to play well for 90 mins—although if they wish to continue to be the most successful club at Guy's this season they must all work harder throughout the game. Goals from Wyeth and Jones were sufficient to secure 2 more points and take the Hospital to the top of the league.

v. Medway. Away. Won 4—2

This game was played on possibly the worst pitch in the South of England against an extremely agricultural side. The game was a classic example of why we must gain promotion from the league at the end of this season. It was very difficult to show any level of skill on that pitch and we soon found ourselves 2—0 down. Guy's continued to try and play decent hockey while Medway set about our ankles with great venom and through Jones 2, Straker 1 and Plowman 1 a 4—2 victory resulted.

Spirochaetes v. Chancres. Won 4—2

With the freshers changed and waiting to play Tiger Thomas and Jug Jones, who were only just persuaded to bring their kit, ordered a late start. This was quick thinking as Barts had just rang to explain why they would be late.

When they finally arrived a token effort of playing started with an idiot called Jones in goal, and still no Captain. Half time came after a magnificent display of devastating hockey by the Spiros with the chief razzler Clive Straker helping Chopper Harris to score from a short corner. Other notable performances came from Niaz Kazime for stickwork and Tiger (the nose) for footwork. Suddenly a bearded apparition appeared, and after giving pathetic British Rail excuses was given the ultimate penalty—no beer for half an hour.

The second half started with Nick "left hand drinking" Harper in goal. Now the Spiros began to play and the chances started to granulate. With the African war cry of "Molese" Clive helped Seb to score after yet another stick set piece move. With the Chancres totally bemused Duncan Jones and Sokhpal "clever dick" Singe scored goals. Two late goals were given away as the Baron and Pete Sanders contracted acute thirst problems. Now with the tedious business of running over (excluding chopper) the last molecules of A.T.P. could now be used in the vigorous partaking of alcoholic beverage.

Soon two ladies' teams arrived to play (Hockey) with the boys. Rumour has it hockey was played though it was difficult to concentrate. The Spiros won 3 out of 4 games to confirm their superiority, with some star female performances from Kristin Pagano (1 goal), Clare, Julie, Helen, Liz and Margaret. Thank you ladies!

With good weather, excellent lunches from Eric and Joyce a very social day was had by all, especially Harry Williams whose performance in checking the free flow of the beer from the half time barrel was exceptional. Barts gave a star performance on the clap clap table whilst Alex starred elsewhere (Hamish type). Thanks to Chopper Harris for chairing and blowing.

D. JONES.

SWIMMING

Staff v. Students Swimming Match

The Staff v. Students swimming match was held at the end of October and is now becoming a popular annual event. This year it was a much more light hearted affair with events for fun rather than of a competitive nature along the lines of an "It's a Knock Out" competition.

In the first event teams warmed up by retrieving corks of their teams' colour which were floating in the pool. This also provided the first opportunity for some underhand activities in the form of concealing other teams corks!

This was followed by a phlebotomist's race in which syringes of red coloured water were ferried across the pool from a dummy patient to a plastic bucket "haematology lab".

The denture-spoon race replaced the more conventional egg and spoon race and added a dental flavour to the proceedings.

The surgeons relay was a popular event in which the "surgeon" had to dress up in a theatre gown, gloves, hat, mask and overshoes and attempt to swim the length of the pool. At the other end he was dragged out, degowned and the next potential surgeon gowned up in the same attire for his length. Luckily we didn't lose too many of our surgeons or potential surgeons by drowning, so next year we may add theatre boots to make things a little trickier.

If you have ever seen a surgical glove inflated to the size of a beach ball you will see why the next event was named the "Udder Race". Attempts to get the appropriate number of gloves blown up and transported down the pool were frought by attempts to burst the udders by members of opposite teams so the whole event was rather chaotic.

The scores were added up after deducting points (particularly from the students) for cheating and the event was declared a draw.

Following the swimming events several staff and students still managed to muster up energy for a water polo game which was great fun in line with the rest of the evening's events.

In all the match was a great success and will hopefully be repeated in a similar manner next year.

MARY GANCZAKOWSKI.

Water Polo—"A winning team from Guy's"

Team: M. Miller, G. Teo, R. Vella, M. Vella, R. Marwood, J. Beard, M Evans, D. Rickard (Capt.), P. Robinson.

Once again Guy's Hospital Water Polo Club entered a team for the University of London Knockout Water Polo Tournament with the intention of putting up a good fight. Last year we drew strong opposition in the quarterfinal and were well beaten. The Guy's Hospital team this year has been substantially reinforced by two newcomers, Ray Vella, a member of the Maltese National Water Polo Team and his brother Mark Vella.

16 Teams entered the competition this year. The first round was held at the University Pool in Malet St. on 22nd November. Our first opponents were University College London who were giving Guy's a 1:2 lead in this handicap competition. We were given a rather generous advantage and consequently we resoundly beat U.C.L. 2:8.

For the quarterfinals, on the following Thursday, we drew St. Bartholomews Hospital, last year's knockout winners.

In the United Hospitals league, cur-

rently being played, we have lost to Barts on two occasions, 5:3 and 6:0. In spite of this, the handicap was revised so we were only given a one goal advantage for this our 3rd encounter. We played consistently well and beat the amazed Barts team 2:5.

We had an easy passage into the final by beating Imperial College III, who were given a 7:0 advantage, 7:12.

In the final we were to meet the Royal Free Hospital 1st team. The final is played over four, five minute quarters as opposed to two, seven minute halves as in previous rounds. The handicaps for this match are therefore doubled. We were to give R.F.H. a six goal start. With a smaller handicap of 3 goals the Royal Free had beaten the London Hospital, the favourites to win the competition, after full time, on penalties in their semi-final.

In the first quarter of the match we played well. Ray Vella and Gabriel Teo swimming well at the front, so we scored two goals.

In the second quarter the pace of the match had our team stretched at the back and we conceded one goal and scored once.

In the third quarter Ray Vella scored one of his best goals. A pass from the mid-field landed slightly short and to the right of Ray and the deep end goal. A nearby defender attacked him but fending him off expertly, Ray moved quickly across the goal to score over the goalkeeper's head with a backhand shot.

In the final quarter our attempts to score the required four goals to draw left room at the back and we gave away a penalty which was safely put in the net. Next in a brisk exchange of goals we scored from a penalty and with one minute to go required 2 goals to draw 10:10.

Mike Miller with renewed energy made two splendid breaks down the left side of the pool to score the vital goals needed. So the game went to extra-time of two, 3 minute halves. Now that we were on level terms we quickly took control of the game and scored two more goals before the end of the match to win 12:10.

After this great victory the team celebrated by drinking the 12 free "jugs" in the ½hr. of the evening left after the presentation of the Cup.

DAVE RICKARD.

Ladies' Water Polo

On Monday, 20th November Guy's Ladies' Water Polo team had their first match against a visiting team. The opposition was a ladies' team from the London Hospital who were also having their first match. Despite the fact that we were all novices the standard of play was very good. Guy's played well with Tracey Maunder, Elizabeth Palmer and Mary Ganczakowski playing in attack and scoring some impressive goals. Sara Leutchford played very well in goal for Guy's and made some really good saves. Co-ordinated teamwork and some hard playing ensured a win for Guy's of 6—2. The match was enjoyed by all who played as well as a few spectators and all deserved the well earned drink afterwards. Many thanks must go to Dave Rickard who kindly organised the game for us and refereed during the match.

Team: Mary Ganczakowski (Capt.), Elizabeth Palmer, Tracey Maunder, Sara Leutchford, Sally Brown, Sally Clark, Louise Aron, Susan Oxborough, Carol Chew, Christine Smith.

M.G.

ROWING

Awakened by a recent article in the *Gazette,* I have put pen to paper in an attempt to prove that the Boat Club (rowing club to the uninitiated) is alive and well.

A Novice VIII was entered for the U.L. Winter Eight's Regatta on November 11th and actually completed the course (despite minor upsets such as having to borrow the London's seats). The captain (who had pretentiously appointed himself coach) provided an eloquent, morale-boosting "team-talk" before the event but the crew was not over-optimistic as they got the boat out. Such was Nick Whifield's concern that he handed his chewing gum to the captain, to be mounted as a memorial in the bar, lest he never return!

The crew boated in plenty of time and while manoeuvring into position they narrowly missed hitting a bridge which they had hoped would give way to a Guy's VIII. Unknown to the VIII the captain had managed to get a ride in the Umpire's launch and was therefore able to see exactly what was going on.

We made an excellent start (totally unpredicted and upsetting all the coach's planned tactics) and gained a canvas over the other two crews: Kings and Imperial College. As we passed the boathouse the crowds cheered but just at that moment stroke gave an almighty heave and was left holding his oar which had become divorced from its fitting on the boat. Cryptic comments ensued from the boathouse commentator while the

remaining members of the crew (under the guidance of "Wounded-Knee" Wood and Dave Horn) struggled on. After about 250m. stroke had recovered and with some determined and hard rowing Guy's narrowed down Imperial's lead from 2 to ½ length. Just as the coach began to feel a little more optimistic disaster struck again: a violent lurch to stroke side caused stroke and 2 to catch a crab simultaneously. This slewed the boat towards the bank but Vince Mak (the cox) restarted the crew immediately and steered a collision course towards Imperial. King's didn't seem to give Guy's any room to go through the bridge so Vince ably steered the crew straight across their bows and we set off in pursuit of the leader.

Unfortunately the finish came too soon as Guy's were rapidly catching Imperial and the final verdict was 1½ lengths. The Umpire, being a Guy's man, calmly ignored our aggressive coxing under the bridge and commented that Guy's were capable of beating Imperial.

The crew also were encouraged and were overheard to be calculating power to mass ratios in the changing rooms. Apparently someone instigated a theory that because they had rowed half the course with 7 men and had only narrowly lost, then they would easily have won with all the crew rowing.

By way of a celebration a Hop was held that night and despite some initial problems (such as the absence of a beer pump—it was in Streatham, and of a D.J.—he was in Sheffield) that too was a success. In spite of giving away a barrel of beer and charging only 35p as an entry fee, a small profit was made and over 180 people actually *enjoyed* themselves.

Don't miss next month's instalment which will be a report of how the crew fared at the United Hospitals Regatta.

The crew was: N. Beechey-Newman (Bow), N. Whitfield, M. Ruprecht, S. Smith, M. Blayney, A. Wood, D. Ham, M. Gaffney (Stroke) and V. Mak (Cox).

W. VAN'T HOFF
(with contributions from "Wounded-Knee" Wood)

MEN'S SQUASH

Unfortunately following in the steps of many sports of Guy's, the Squash Club did badly last year, two of the men's teams being lucky to escape demotion. However, this prompted a regular team training session which has on the whole been very successful.

Due to the pre-season training, the results of all teams are better than this time last year, though they may not seem impressive.

The Cumberland Cup team has done worst having lost 5 and won only 1 match. Nonetheless we are picking up some points with Ian Nicholson and Colin Holden playing particularly well. Team from: I. Nicholson, C. Holden, J. Farquharson, P. Collins, D. Webber, A. Morgan, V. Tun.

The League I team is quite strong this year and has accumulated quite a few points already, having won 4 and lost 2 matches. Team from C. Holden, J. Farquharson, D. Webber, V. Tun, I. Nicholson, A Morgan, M. Yaffé.

League II hasn't done so well, having lost 3 and won 2 matches. The team seems strong enough to do better but it has been difficult to get a regular team. Team from: A. Morgan, P. Sanders, S. Des Clayes, J. Pringle, N. Higgins, J. Murch, T. Thurston, M. Yaffé, J. Moore.

The League III team is now in Div. V of the V.L.S.L. and it is hoped to start matches in this newly formed Div. in the second half.

The Guy's Gonads have played the regular friendly fixtures and though perhaps the results should not matter, we have done well winning 7 and losing 4 matches against teams like O.L.S., Courages, Artists, Royal Naval College, Law Society. Teams selected from regular team players and those who only play the occasional match.

V.T.

LADIES' SQUASH

Guy's Ladies' have made an enthusiastic start to the new squash season. University of London league matches are well under way and we field two ladies' teams.

Match results so far:

Guy's I —	v. St. Georges	—Guy's 3—1
	v. U.C.H.	—Guy's 3—1
	v Barts	—Draw 2—2
	v. St. Marys	—Guy's 4—0
	v. City	—City 3—1

Guy's I team: Hannah Madin, Jill Simmonds, Kay Worrell and Jenny Hayward.

Guy's II —	v. U.C.L.	—Guy's 3—1
	v. Ch. X	—Ch. X 2—2
	v. Royal Free	—R.F. 1—3
	v. Chelsea	—Chel. 2—2

Guy's II team: Fiona Clark, Lynne Tester, Diane Wells, Jill Lake, Clare Watts, Marcia King.

Hospital Information

PAPERS BY GUY'S MEN

Ashley, F. P. *and* Wilson, R. F. The relationship between dietary sugar experience and the quantity and biochemical composition of dental plaque in man. **Archieves of Oral Biology,** 1977, **22,** 409.

Bathard-Smith, P. J. *and* Markus, A. F. Hodgkin's disease presenting intra-orally. **British Journal of Oral Surgery,** 1978, **16,** 64.

Beeching, B. W. Dental radiology. 1. Normal anatomy. **Dental Update,** 1978, **5,** 361.

Braithwaite, R. A. *and another.* Cardiac effects of tricyclic antidepressant medication. A preliminary study of nortriptyline. **British Heart Journal,** 1978, **40,** 1005.

Brown, D. *and another.* A clinical and laboratory investigation of a new denture cleaner. ***Journal of Dentistry,*** *1978,* ***6,*** 222.

Buisseret, P. Clinical challenge: why was the patient's mouth sore? **Modern Geriatrics,** 1978, **8** (10), 9.

Burn-Murdoch, R. A. *and another.* A technique for measuring eruption rates in rats of maxillary incisors under intrusive forces. **Archives of Oral Biology,** 1978, **23,** 563.

Curry, P. V. L. *and* Raper, D. A. Single lead for permanent physiological cardiac pacing. **Lancet,** 1978, **2,** 757.

Dische, S. Childhood enuresis: a family problem. **Practitioner,** 1978, **221,** 323.

Ewart, M. Emergency allowances in the community health services. (Correspondence.) **British Medical Journal,** 1978, **2,** 1091.

Greenwald, S. E., Newman, D. L. *and* Bowden, N. L. R. Comparison between theoretical and directly measured pulse propagation velocities in the aorta of the anaesthetised dog. **Cardiovascular Research,** 1978, **12,** 407.

Grenby, T. H. *and* Bull, J. M. Dental caries in laboratory rats from breakfast cereals and its control by a calcium glycerophosphate additive. **Archives of Oral Biology,** 1978, **23,** 675.

Holt, D. W. *and another.* Mexiletine in the management of ventricular dysrhythmias. (Correspondence.) ***European Journal of Cardiology,*** 1978, **8,** 121.

Hughes, R. A. C. *and others.* Controlled trial of prednisolone in acute polyneuropathy. **Lancet,** *1978,* **2,** *750.*

Jackson, K. M., Joseph, J. *and* Wyard, S. J. A mathematical model of arm swing during human locomotion. **Journal of Biomechanics,** 1978, **11,** 277.

Kinder, C. H. *and others.* Report of the standing committee on urological instruments: endoscopes. **British Journal of Urology,** 1978, **50,** 361.

Lewis, R. R., Beasley, M. G., Hyams, D. E. *and* Gosling, R. G. Imaging the carotid bifurcation using continuous-wave Doppler-shift ultrasound and spectral analysis. **Stroke,** 1978, **9,** 465.

Lewis, R. R. *and* Gosling, R. G. Supraorbital fluorescein test in diagnosis of internal-carotid-artery disease. (Correspondence.) **Lancet,** 1978, **2,** 839.

Mace, M. C. Oral African histoplasmosis resembling Burkitt's lymphoma. **Oral Surgery, Oral Medicine, Oral Pathology,** 1978, ***46,*** 407.

Marwood, R. P. Anuria in pregnancy. **British Medical Journal,** 1978, **2,** 931.

Owen, W. J., Gleeson, M. J. *and* McColl, I. Thyroid crisis and tracheal compression in patient with retrosternal goitre. **British Medical Journal,** 1978, **2,** 997.

Rowe, A. H. R. *and another.* Dental impressions. The probability of contamination and a method of disinfection. **British Dental Journal,** 1978, **145,** 184.

Rubens, R. D. The current status of adjuvant chemotherapy. **Surgical Clinics of North America,** 1978, **58,** 789.

Rubens, R. D., Millis, R. R., Hayward, J. L. *and others.* Oestrogen receptors and the response to endocrine therapy in advanced breast cancer. **British Journal of Cancer,** 1978, **38,** 431.

Scully, C. *and* Lehner, T. Autoimmunity and oral disease. **Dental Update,** 1798, **5,** 379.

Simmonds, A. Crisis in clinical science. **World Medicine,** 1978, **14** (1), 94.

Simmonds, H. A., Sahota, A. *and others.* Adenine and adenosine metabolism in intact erythrocytes deficient in adenosine monophosphate - pyrophosphate phosphoribosyltransferase a study of two families. **Clinical Science and Molecular Medicine,** 1978, **55,** 407.

Wainwright, R. J. *and* Maisey, M. N. Nuclear medicine. 4: Cardiac imaging. Part 1: myocardial perfusion scintigraphy. **Hospital Update,** 1978, **4,** 623.

Wiseman, H. M. *and* Hampel, G. Cardiac arrhythmias due to chloral hydrate poisoning. (Correspondence.) **British Medical Journal,** 1978, **2,** 960.

Yates, A. Dopamine and dobutamine. (Correspondence.) **British Medical Journal,** 1978, 2, 1163.

HOUSE APPOINTMENTS

GUY'S HOSPITAL
1st January, 1979

House Physicians

Dr. Scott, Dr. Joiner, Dr. Grahame and Dr. Gibson	Mr. R. G. Henderson to 31.1.79
	Mr. M. J. Humphries to 31.1.79
	Mr. C. C. Trounce to 31.1.79
Prof. Lessof, Prof. Keen, Prof. Dowling and Dr. Maisey	*Miss D. M. Mitchell to 31.7.79
	Mr. G. W. Beynon to 31.1.79
	Miss S. A. Amiel to 31.1.79
Dr. Houston, Prof. Trounce, Dr. Knight and Dr. Grimble	Mr. T. J. Palmer to 31.7.79
	Mr. N. J. Morrish to 31.1.79
	Mr. W. A. Sudell to 31.1.79

House Surgeons

Mr. Maynard	*Mrs. J. P. Findlay to 31.7.79
Mr. Ellis	Mr. A. K. Jones to 31.1.79
Mr. Beard	Mr. S. J. Forsdick to 31.1.79
Mr. O'Flynn and Dr. Winter Mr. Glover	Mr. J. R. Britton to 31.1.79
	Mr. A. H. M. Heagerty to 31.1.79

* *Pending Qualification*

Mr. Rendall	Mr. M. C. Harrison to 31.1.79
Prof. McColl and Mr. Bewick	Miss M. C. Holloway to 31.1.79
	Mr. J. A. Pain to 31.1.79

Gynaecological House Surgeon

Mr. Coltart and Mr. Tomkinson	Miss C. I. F. Rooney to 31.1.79
Mr. Lewis and Mr. Morris (linked to Surgery)	Mr. I. J. Page to 31.7.79

Throat and Ear House Surgeon

(Linked to Prof. McColl)	*Mr. J. W. Mason to 31.7.79
(Linked to Prof. McColl)	Mr. R. M. Terry to 31.1.79

Orthopaedic House Surgeon

(linked to Mr. Glover)	Mr. A. R. Johns to 31.1.79
	Mr. J. Hancock to 31.1.79
	Mr. M. Houghton to 31.1.79

Genito-Urinary House Surgeon

	Mrs. A. Holden to 31.1.79
	Mr. R. M. Atkins to 31.1.79

Thoracic House Surgeon

	Mr. N. R. Womack to 31.1.79

ST. OLAVE'S HOSPITAL

House Physician	Mr. J. S. Aldis to 31.7.79
	Miss G. C. Vafidis to 31.1.79
House Surgeon	Mr. P. Howard to 31.1.79

NEW CROSS HOSPITAL

H.P. in General Medicine and Rheumatology (4 months)/Geriatrics (3 months)	Mr. R. M. Buchdahl to 31.1.79
	Miss A. M. Owen to 31.7.79
H.P. in Geriatrics (4 months)/General Medicine and Rheumatology (3 months)	Miss J. P. M. Evans to 31.1.79
	*Mr. C. J. Jackson to 31.7.79

BECKENHAM HOSPITAL

House Physician to Dr. Rawlings and Dr. Joiner	Mr. N. C. G. Bathurst to 31.1.79

GREENWICH DISTRICT HOSPITAL

House Physician to Dr. Thomson Dr. Hartley and	Mr. N. J. Masters to 31.7.79
	Mr. I. D. Entwistle to 31.1.79
House Physician to Dr. Robson and Dr. Blower	Mr. G. J. A. Joy to 31.1.79
House Physician to Dr. Colover and Dr. Marsden	Mr. J. D. Taylor to 31.1.79
House Physician to Dr. Robson	Mr. B. Newmarch to 31.7.79
House Surgeon to Mr. Williams and	Mr. A. T. Tylee to 31.1.79
Mr. Park for 3 months and 3 months with Mr. Stoker and Mr. Harrison	Mr. R. T. Thompson to 31.1.79
House Surgeon to Mr. Stoker and	Miss S. Dunn to 31.1.79
Mr. Harrison for 3 months and 3 months with Mr. Williams and Mr. Park	Mrs. V. J. Bolton to 31.1.79
House Surgeon to Mr. O'Flynn, Mr. Wilson and Mrs. Wengraf	*Mr. J. W. A. Moore to 31.7.79

ASHFORD HOSPITAL, KENT

House Surgeon	Mr. D. F. Dayson to 31.1.79

HITHER GREEN HOSPITAL

House Physician in General Medicine and Infectious Diseases	Mr. L. C. Koo Seen Lin to 31.1.79
	Mr. P. K. Goutam to 31.1.79

LEWISHAM HOSPITAL

House Physician to Dr. Price	Mr. P. F. Shipton to 31.1.79
House Physician to Dr. Stott	Mr. A. J. Davis to 31.1.79
	Mr. N. C. G. Bathurst to 31.1.79
House Physician to Dr. Staffurth	Mr. G. A. Shun-Shin to 31.1.79
	Mr. R. G. T. Glynne-Jones to 31.1.79
House Physician to Dr. Mallinson	Mr. D. A. Keable-Elliott to 31.1.79
House Surgeon to Mr. Lynn Evans	*Mr. J. D. Gray to 31.7.79
House Surgeon to Mr. Ivo Smith	Mr. D. Beswick to 31.1.79
House Surgeon to Mr. Monty	Mr. M. P. Hirsch to 31.1.79
House Surgeon to Mr. Le Brun	Mr. A. S. E. Bristow to 31.1.79
House Surgeon to Mr. Negus	Miss S. J. Comper to 31.1.79
House Surgeon to Mr. Beavis	Mr. E. Refsum to 31.1.79

ORPINGTON HOSPITAL

House Surgeon to Mr. Wilding and Mr. Lam	Mr. M. D. Couper to 31.7.79
	Miss A. J. Dismorr to 31.1.79
House Surgeon to Mr. Walker-Brash and Mr. Ratnesar	*Miss A. Clark to 31.7.79
House Surgeon to Mr. Boxall and Miss Austin	Mr. S. J. Sperring to 31.1.79
House Surgeon to Mr. Walker-Brash and Mr. Glasspool	Mr. A. G. Long to 31.1.79
House Physician to Dr. Southwell, Dr. Williams and Dr. Wharton	Mr. R. Coates to 31.7.79
	Mr. J. R. A. Duckworth to 31.1.79

PEMBURY HOSPITAL

House Surgeon to Mr. Gibson and Mr. Lavy	Mr. D. L. Williams to 31.1.79
House Physician to Dr. Maw, Dr Everest and Dr. King	*Mr. H. W. Pritchard to 31.7.79
	Mr. D. J. T. Wright to 31.1.79
	Miss S. E. Perfect to 31.1.79

GUY'S HOSPITAL

1st February, 1979

House Physicians

Dr. Scott, Dr. Joiner, Dr. Grahame and Dr. Gibson	Mr. P. J. Howard to 31.7.79
	Mrs. A. Holden to 31.7.79
	Mr. N. P. Hirsch to 31.7.79

* Pending Qualification

Prof. Lessof, Prof. Keen, Dr. Dowling and Dr. Maisey	*Miss D. M. Mitchell to 31.7.79 Mr. R. M. Atkins to 31.7.79 Mr. S. J. Forsdick to 31.7.79
Dr. Houston, Prof. Trounce, Dr. Knight and Dr. Grimble	Mr. T. J. Palmer to 31.7.79 Mr. A. H. M. Heagerty to 31.7.79 Mr. M. C. Harrison to 31.7.79
Geriatric Medicine/ General Medicine	Mr. A. T. Tylee to 30.4.79

House Surgeons

Mr. Maynard	*Mrs. J. P. Findlay to 31.7.79
Mr. Ellis	Mr. D. D. I. Wright to 30.4.79 Mr. I. Crate to 31.7.79
Mr. Beard	Mr. J. M. Twomey to 31.7.79
Mr. O'Flynn and Dr. Winter	Miss A. Nixon to 30.4.79 Mr. G. Beynon to 31.7.79
Mr. Glover	Mr. C. P. Gilford to 31.7.79
Mr. Rendall and Dr. Tong	Mr. J. Duckworth to 30.4.79 Mr. C. Archer to 31.7.79
Prof. McColl and Mr. Bewick	Mr. W. A. Sudell to 31.7.79 Mr. N. J. Morrish to 31.7.79

Gynaecological House Surgeon

Mr. Coltart and Mr. Tomkinson	Mr. W. S. Whitby (linked to Prof. McColl) to 31.7.79
Mr. Lewis and Mr. Morris (linked to General Surgery)	Mr. I. J. Page (linked to Mr. Rendall) to 31.7.79

Throat and Ear House Surgeon

(linked to Prof. McColl)	*Mr. J. W. Mason to 31.7.79

Orthopaedic House Surgeon

(linked to Mr. Glover)	Mr. T. A. Underwood to 31.7.79
Orth-Guy's/Gen. Sur. St. Olave's	Mr. De Sousa to 30.4.79 Miss J. Evans to 31.7.79
Orth-NX/Gen. Sur. St. Olave's	to 30.4.79 Mr. D. Jones to 31.7.79

Genito Urinary House Surgeon

*Mr. I. Crate to 30.4.79
Mr. D. Wright to 31.7.79

DISTRICT GENERAL HOSPITAL, EASTBOURNE

House Physician to Dr. Macleod	Mr. S. J. Sperring to 31.7.79

WEST SUFFOLK HOSPITAL, BURY ST. EDMONDS

House Physician to Dr. Evans	Mr. E. Refsum to 31.7.79

JOYCE GREEN HOSPITAL, DARTFORD

House Physician to Dr. Goldman	Mr. M. W. Houghton to 31.7.79
House Physician to Dr. Wise	Mr. G. J. Tamlyn to 31.7.79

CUCKFIELD HOSPITAL, SUSSEX

House Surgeon	Mr. I. Lolin to 31.7.79

ISLE OF THANET HOSPITAL, RAMSGATE

House Physician to Dr. Cocking	Mr. J. C. Gay to 31.7.79

WEST KENT HOSPITAL

House Surgeons	Mr. Zarb to 31.7.79 Mr. C. Archer to 30.4.79 Mr. J. Duckworth to 31.7.79

Thoracic House Surgeon

Mr. G. W. Beynon to 30.4.79
Miss A. Nixon to 31.7.79

ST. OLAVE'S HOSPITAL

House Physician	Mr. J. S. Aldis to 31.7.79 *Miss H. J. Milburn to 31.7.79
House Surgeon	Miss J. Evans to 30.4.79 Mr. D. Jones to 30.4.79 Mr. De Sousa to 31.7.79

NEW CROSS HOSPITAL

H.P. in Gen. Med. to 30.4.79 and Rheumatology/ Geriatrics	Miss A. M. Owen to 31.7.79
H.P. in Geriatrics to 30.4.79/ Gen. Med. and Rheumatology	*Mr. C. J. Jackon to 31.7.79
H.P. in Gen. Med., Chest Medicine	*Mr. T. C. Owen to 31.7.79
H.P. in Geriatrics/ Gen. Med. and Chest Medicine	Miss C. Rooney to 31.7.79

BECKENHAM HOSPITAL

House Physician to Dr. Rawlings and Dr. Joiner	Mr. R. G. C. Martin to 31.7.79

GREENWICH DISTRICT HOSPITAL

H.P. to Dr. Hartley and Dr. Thomson	Mr. N. J. Masters to 31.7.79 Miss S. J. Comper to 31.7.79
House Physician to Dr. Robson and Dr. Blower	Miss M. C. Hollway to 31.7.79
House Physician to Dr. Colover and Dr. Marsden	Miss S. Dunn to 31.7.79
House Physician to Dr. Robson	Mr. B. Newmarch to 31.7.79
House Surgeon to Mr. Williams and	Mr. P. F. Shipton to 31.7.79
Mr. Park for 3 months and 3 months with Mr. Stoker and Mr. Harrison	Mr. D. A. Keable-Elliott to 31.7.79
House Surgeon to Mr. Stoker and Mr. Harrison for 3 months and 3 months with Mr. Williams and Mr. Park	Mr. M. J. Humphries to 31.7.79 Mr. C. C. Trounce to 31.7.79
House Surgeon to Mr. O'Flynn, Mr. Wilson and Mrs Wengraf	*Mr. J. W. A. Moore to 31.7.79

** Pending Qualification*

ASHFORD HOSPITAL

House Surgeon	*Miss R. C. Hunt to 31.7.79

HITHER GREEN HOSPITAL

House Physician in General Medicine and Infectious Diseases	Mr. M. J. Margetts to 31.7.79 Mr. R. M. Terry to 31.7.79

LEWISHAM HOSPITAL

House Physician to Dr. Price	Mr. D. Beswick to 31.7.79
House Physician to Dr. Stott	*Mr. M. Gill to 31.7.79 *Mr. P. M. Tillman to 31.7.79
House Physician to Dr. Staffurth	Mr. R. T. Thompson to 31.7.79 Mr. A. S. E. Bristow to 31.7.79
House Physician to Dr. Mallinson	Mr. A. K. P. Jones to 31.7.79
House Surgeon to Mr. Lynn Evans	*Mr. J. D. Gray to 31.7.79
House Surgeon to Mr. Ivo Smith	Mr. J. R. Hogg to 31.7.79
House Surgeon to Mr. Monty	to 31.7.79
House Surgeon to Mr. Le Brun	Miss G. C. Vafidis to 31.7.79
House Surgeon to Mr. Negus	Mr. R. G. T. Glynne-Jones to 31.7.79
House Surgeon to Mr. Beavis	Mr. H. Watkin to 31.7.79

ORPINGTON HOSPITAL

House Surgeon to Mr. Wilding and Mr. Lam	Mr. M. D. Couper to 31.7.79 Mr. G. J. A. Joy to 31.7.79
House Surgeon to Mr. Walker-Brash and Mr. Ratnesar	*Miss A. Clark to 31.7.79
House Surgeon to Mr. Boxall and Miss Austin	*Mrs. J. Williams to 31.7.79
House Surgeon to Mr. Walker-Brash and Mr. Glasspool	Mr. J. A. Shun-Shin to 31.7.79
House Physician to Dr. Southwell, Dr. Williams and Dr. Wharton	Mr. R. Coates to 31.7.79 Mr. D. L. Williams to 31.7.79

PEMBURY HOSPITAL

House Surgeon to Mr. Gibson and Mr. Lavy	Mr. R. G. Henderson to 31.7.79 Miss S. A. Amiel to 31.7.79
House Physician to Dr. Maw, Dr. Everest and Dr. King	*Mr. H. W. Pritchard to 31.7.79 Mr. D. F. Dayson to 31.7.79 Mr. J. A. Hancock to 31.7.79

DREADNOUGHT SEAMEN'S HOSPITAL

House Surgeon	Mr. Carabott to 31.7.79
House Physician	Mrs. V. J. Bolton to 31.7.79

ST. MARY'S HOSPITAL, EASTBOURNE

House Physician to Dr. Linley Adams	Mr. A. G. Long to 31.7.79

ST. HELEN'S HOSPITAL, HASTINGS

House Physician to Dr. Irvine and Dr. Strouthidis	to 31.7.79 Mr. R. C. Nicholas to 31.7.79

KENT AND CANTERBURY HOSPITAL

House Surgeon to Mr. Collins	to 31.7.79

EDGWARE GENERAL HOSPITAL

House Surgeon to Mr. Qureshi	Miss J. S. Westbury to 31.7.79

* Pending Qualification

PASS LISTS

UNIVERSITY OF LONDON

M.Sc.—Science

R. Hewamanna (Radiation Biology)

M.Sc.—Medicine

W. A. M. Al Shaikh (Nuclear Medicine)
E. J. Grant (Periodontology)

ROYAL COLLEGE OF SURGEONS OF ENGLAND

Diploma of Fellow in Dental Surgery

Hickman, R. E.

Diploma of Licentiate in Dental Surgery

Oscroft, N. J.
Wilmott, R. W.

Diploma in Dental Public Health

Cheeseman, L. J.
Renner, W. A. A.

UNIVERSITY OF LONDON FACULTY OF MEDICINE

Preliminary Examination for Studies in Medical Subjects

Barratt, E. M.
Hart, J. F.
Tucker, I. L.

NEWLY QUALIFIED

Archer, C. B.—M.B, B.S. (October 1978)

Aldis, J. S.—L.R.C.P., M.R.C.S. (October 1978)*

Gibson, J. A.—L.R.C.P., M.R.C.S. (July 1978)* M.B., B.S. (October 1978)

Jarrett, P. H.—M.B., B.S. (October 1978)

Newmarch, B.—L.R.C.P., M.R.C.S. (October 1978)*

Owen, Miss A. M.—L.R.C.P., M.R.C.S. (October 1978)*

Page, I. J.—L.R.C.P., M.R.C.S. (October 1978)*

Underwood, T.A.—L.R.C.P., M.R.C.S. (October 1978)*

Student Medical Education Committee 1978

J. Barker
L. N. Denmark (Secretary)
S. Girling
T. Houlding
N. Kendall
G. Noble
P. O'Hare
P. J. Razzell (Chairman)
P. Sartori
W. Scott Smith
W. Vant Hoff

THE SIR COSMO AND LADY MABEL BONSOR SCHOLARSHIP

This Scholarship is awarded each year and applications are invited from members of the Guy's Hospital Nurses' League. The closing date is 29th December, 1978, and applications should be sent to the Hon. Sec., G.H. Nurses' League, c/o Nursing Administration, Guy's Hospital, London, SE1 9RT.

LESLIE HILLMAN PRIZE IN HAEMATOLOGY, 1980

The format of the above Prize examination has been changed and it will now be based on a research project. Entrants for the Prize may select their own topic or seek advice from Dr. P. Barkhan or Dr. K. C. G. Clark, Department of Haematology, 4th Floor Guy's Tower. The work should be presented in the form of a scientific paper, about 5,000 words in length. The completed paper should be sent to the School office by the end of May 1980.

ENGAGEMENT

The engagement is announced between Alasdair Jacks and Jacqueline Wright.

BIRTH

JOHNSON.—To Wendy (née Aris) and Stephen, on 14th September 1978, a daughter, Lucinda Emmaline Aris, at Pembury Hospital.

MARRIAGE

Dr. SUSAN ANN STAPLES to Dr. JOHN JAMES McCARTHY on 23rd September, 1978.

DEATHS

Mr. ERIC H. L. SANDER, L.D.S. (1923), late of Worthing, died in Southlands Hospital on 27th October, 1978.

Mr. JAMES RODNEY FERRIER POPPLEWELL (qualified M.R.C.S., L.R.C.P. at Guy's 1929), died at home on 4th November, 1978.

CHANGES OF ADDRESS

Dr. and Mrs. N. Howard Allen, 45 Lock Chase, Lee Park, Blackheath, London, SE3 8HB.

Mr. M. C. and Mrs. F. E. Mace, The Malt House, Walton Road, Aylesbury, Buckinghamshire.

N. J. Odom, 4 Pegwell Close, Hastings, Sussex, TN34 2TE.

Deryck and Annette Chant (née Pountain), Granby House, 16 East Avenue, Talbot Woods, Bournemouth. Tel. (0202) 26404 (residence only).

Dr. and Mrs. J. B. Kelynack, The Coach House, Underriver, Sevenoaks, Kent.

PERSONAL

PART-TIME SECRETARY.—To assist in interesting work concerned entirely with an international scientific association. Professor Roger Warwick, Dept. of Anatomy, G.H.M.S. Ext. 3358.

SINGLE LADY seeking part-time (2 afternoons per week) reception duties in Harley Street. Contact Miss A. Cook, 50 Corner Field, Streatham Hill, London, S.W.2.

WANTED.—Children's garden swing. Phone Mary, ext. 3374.

THE WILLS LIBRARY,
GUY'S HOSPITAL,
LONDON, S.E.1.